

HARVARD MEDICAL

ALUMNI BULLETIN

FALL 1986

Alumni Day
Class Day
1986

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ALUMNI BULLETIN / FALL 1986 / VOL. 60 NO. 3

FEATURES

- 9 Campaign for the Third Century of Harvard Medicine
- 10 Letter from the Dean of the Faculty of Medicine by *Daniel C. Tosteson*
- 12 Campaign Goals
- 13 On Learning to Learn at HMS by *Lewis Thomas*
- 15 Update on the New Medical Education Center
- 16 Letter from the Dean for Students and Alumni by *Daniel D. Federman*
- 18 Vanderbilt Hall Redux
- 20 Campaign Leadership
- 22 Alumni Day
- 26 Social Admit: Close encounter of the third year by *James Oliver*
- 29 Surgery and Healthy People: Lifestyle as preventive medicine by *Tenley E. Albright*
- 30 Observations from the Corporate World: The physician's place in the thoughtware economy by *David L. Birch*
- 33 The Relaxation Response: How to lower blood pressure, cope with pain, and reduce anxiety in 20 minutes a day by *Herbert Benson*
- 36 Class Day
- 40 The Seven Ages of the Medical Student: A refrain for our times by *William H. Thomas*
- 41 Recent Developments in Medicine: On facing the brave new world, from AIDS to DRGs by *Albert M. Maguire*
- 42 The Returns Are In: Poll results on what got the Class of 1986 through HMS, from Harold the mailman to Big Sami's sandwiches by *Roger E. Mosesson*
- 44 Speaking Out—And Listening Too: The doctor as public servant by *Lawrence K. Altman*
- 47 The Care of the Patient—1986: Applying the lessons of a bygone age by *Ronald Arky*

DEPARTMENTS

- 2 Inside HMAB
- 4 Alumni Council: President's Report by *James A. Pittman Jr.*
- 5 Pulse: Taplin Professorship, AIDS consortium, teaching awards, new partnership for McLean
- 49 Reunion Reports
- 56 Alumni Notes
- 62 In Memoriam: Augustus Thorndike, David D. Rutstein
- 64 Death Notices

Cover: Harvard University president Derek C. Bok and Harvard Medical School dean Daniel C. Tosteson discuss the Campaign for the Third Century of Harvard Medicine in the lobby of Vanderbilt Hall this past summer. At the April groundbreaking for HMS's Medical Education Center, Bok said, "I dare say no other faculty is addressing the quality of education more forcefully and more creatively than the Faculty of Medicine." Photograph by Ken Haas. Corner Class Day photograph by Jerry Berndt.

INSIDE H.M.A.B.

Lewis Carroll would have called this a portmanteau issue. It packs together the Campaign for the Third Century of Harvard Medicine with the traditional record of this year's Alumni Day and Class Day.

The dean leads off with a call to the colors—the challenges and rewards that lie ahead. Then Lewis Thomas '37, co-chairman of the National Campaign—our most articulate prophet, whose musings know no bounds—reminds us what Harvard medicine is all about. Dan Federman, as dean for students and alumni and, therefore, *ex officio* friend of the Bulletin, completes the exhortation.

Spake Joe Garland '19, editor of sainted memory, in his memoirs: "... the *Bulletin's* most valuable function is that of providing a means of communication between the alumni and the medical school... never has the need for alumni support been greater than in the present difficult time." So expect to hear a great deal about this campaign in issues to come now that Harvard has had its 350th!

No torrential downpour could dampen the proceedings of Alumni Day or the wit of its chairman, Ron Zimmerman '61. Everything had been moved into Amphitheater C.

James Oliver, future alumnus of the Class of '87 read a most compelling essay, *Social Admit*, which should go a long way to reassure those who feel that today's medical student is blind to human values. Tenley Albright '61 follows. Who knows better the meaning of *mens sana in corpore sano*? David Birch, a brilliant auslander from MIT and Cognetics Inc., jolts our isolation telling us how the corporate world of Fortune 500 regards the medical profession. It takes Herb Benson '61 to calm our fears with humor and the relaxation response.

On Class Day, amid torrential rain and the shrieking of canvas, the students spoke well. And so did their invited speakers, Lawrence Altman of New York University and *The New York Times* and Ronald Arky of Cambridge's Mt. Auburn Hospital, who urge us to speak out but also to listen. Sage advice and behind it all the benevolent shadow of Francis Peabody.

So give heed and attend to Harvard Medical School in its third century. We are off and running.

—Gordon Scannell

HARVARD MEDICAL

ALUMNI BULLETIN

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ALUMNI COUNCIL: PRESIDENT'S REPORT

New Plans for the Alumni Office

by James A. Pittman Jr.

First, thank you for electing me your president. I shall do my best to represent the alumni and to support the school and its administration in keeping HMS in the lead.

As many of you know, late last year Will Cochran announced his desire to retire as director of alumni relations at the end of his three-year term in July 1987, to devote more of his efforts to the practice of neonatology. To initiate the search for a successor, Clem Hiebert appointed a committee consisting of David Marcello '56 (chairman), A.W. Karchmer '64, Jane Schaller '60, and myself.

Before the committee could act, however, we needed to settle the question of what kind of individual we should look for. We considered the possibility of finding a strong non-M.D. administrative director over whom the president or council as a whole would function in a supervisory role.

On Monday, July 21, the Alumni Council held a meeting by telephone conference call. After considerable discussion, the council voted unanimously to adopt this new organizational method of operating the Alumni Office. David Marcello's committee will search for an administrator rather than a physician.

The obvious concern here is that the office might become more bureaucratic and less directly related to alumni. However, a full-time administrator of alumni affairs could be more effective in running the logistical and day-to-day operational details of the office than could a part-time physician without such a higher-level, full-time administrator.

The Alumni Council president will also serve as director of alumni affairs; continuity will be provided by our three presidents—the actual president and the two presidents-elect—at least one of whom will be from the Boston area, according to tradition.

Additional details and other topics will follow.

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PULSE

**Cravalho Named
Taplin Professor**

Engineer, entrepreneur, and inventor John Taplin has built a bridge between medicine and mechanical engineering: with his wife Virginia and their five children, he has given the first fully endowed professorship in the joint HMS-MIT Division of Health Sciences and Technology (HST). Shared by HMS and MIT, the chair in medical engineering is named for Taplin's late brother Edward Hood Taplin, who died of kidney failure before dialysis was invented. John Taplin hopes the new chair will encourage "the development and evaluation of technology for clinical use."

Ernest Cravalho, the chair's first incumbent, applies engineering expertise to problems ranging from cryopreservation of blood and livestock embryos to designing a prosthetic bladder and instruments that lessen the risk of treating cardiac arrhythmias. He is Matsushita Profes-



Ernest Cravalho



John and Virginia Taplin

sor of Mechanical Engineering in Medicine at MIT, chair of the Department of Biomedical Engineering at Massachusetts General Hospital, and former associate director for medical engineering and medical physics in HST.

Cravalho began his investigation of cryopreservation soon after he came to MIT in 1966. He and his students invented the first fully programmable cryomicroscope to observe and measure cells and tissues during freezing and thawing. Since 1970 he has collaborated with Charles Huggins, HMS associate professor of surgery and director of the MGH blood bank, on improving the technology of blood preservation.

Cravalho and his team are also involved in the effort to increase the numbers of "supercows"—selectively bred animals that produce much more milk than ordinary cows. Supercows can produce up to 50 embryos a year through hormone stimulation and artificial insemination; the fertilized ova are then implanted in ordinary cows.

Cravalho and colleagues are developing an economically feasible method of cryopreservation for packaging and transporting the "superembryos" so they can be shipped and stored until the recipient cows are at the right point in their reproductive cycles to receive them. His lab is also collaborating with veterinarians from Tufts University on application of the technology to pigs.

At the request of researchers at West Roxbury V.A. Hospital, Cravalho designed a device to measure obstruction in the urinary tract and collaborated with them in creating a model for the flow of fluids through the lower urinary tract.

"I had no idea of the magnitude of bladder problems of spinal cord patients before I began working with the V.A. Hospital," says Cravalho. These patients' bladders often become nonfunctional and diseased. Cravalho is currently designing a prosthetic bladder, using materials that discourage mineral deposits.

Cravalho has also designed instruments to treat some cardiac arrhythmias using a catheter instead of the riskier and more expensive open-chest surgery. The instruments are now being tested on animal models.

In endowing the Edward Hood Taplin Professorship, John Taplin hopes to "bind the complementary talents of MIT and HMS researchers closer together, getting different disciplinary approaches and perspectives to look at the same problem." A graduate of MIT and an inventor (he holds 65 U.S. and foreign patents), Taplin works with HMS's Office of Technology Licensing and Industry-Sponsored Research. Last year he established the National Health Research Foundation "to promote and support promising, embryonic ideas and inven-

tions to improve human health and the quality of life, and to bring such ideas into products for public use in an expeditious and effective manner." □

AIDS Consortium Gets NIH Funding

HMS faculty members from five Harvard-affiliated teaching hospitals have joined together in an unprecedented collaborative effort called the Harvard AIDS Treatment Evaluation Group. The group was selected recently as one of 14 centers nationwide to receive NIH funding to study drugs that may help AIDS patients. NIH plans to spend a total of \$100 million to fund the studies; the Harvard group will receive \$8.6 million over five years.

Part A of the NIH funding supports testing of agents that may combat the AIDS virus. Part B supports testing of drugs that may be effective against the opportunistic infections, malignancies, and neurological disorders associated with the disease. The Harvard group has been funded for both parts.

Advantages of a collaborative group, explains principal investigator Martin Hirsch, who heads MGH's branch of the group, include the ability to "study a large number of relatively homogeneous patients in a short time, and to tap the collective abilities of a large number of investigators." Hirsch is HMS associate professor of medicine and director of the MGH Infectious Disease Unit.

Other participating Harvard-affiliated hospitals include:

- New England Deaconess Hospital, where Jerome Groopman, associate professor of medicine, A.W. Karchmer '64, associate professor of medicine, and J. Davis Allan, instructor in medicine, are co-leaders of the research team;

- Beth Israel Hospital, where Clyde Crumpacker, associate professor of medicine, heads the research;

- Children's Hospital, where Kenneth McIntosh, professor of pediatrics, directs the research; and

- Dana-Farber Cancer Institute, where Donald Kufe, HMS associate professor of medicine, provides information on the drugs' actions and effects, safety and toxicity, and how they are metabolized.

Representatives from the 14 national centers met at NIH in July to discuss the kinds of trials to be undertaken in the project. Five or six drugs—probably including ribavirin, azidothymidine (AZT), alpha interferon, foscarnet, HPA-23, and didoxycytidine—will be tested in the first year, with a total of 1,000 patients involved in the studies. Subgroups from the 14 centers are now coming up with study protocols; as each protocol is approved by a steering committee, the centers will be given the opportunity to participate.

As of this writing, the Harvard group's study protocols have not yet been set. It seems likely, though, that at least some of its work will build on earlier investigations by its members. This past year, Crumpacker and Hirsch participated in a multi-center

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Press conference to announce consortium: Martin Hirsch of MGH (at podium), Jerome Groopman of New England Deaconess, Donald Kufe of Dana-Farber, Glenn Bubley of Beth Israel, Kenneth McIntosh of Children's

PHOTO BY SHARON BRAY

trial of alpha interferon, and Hirsch and Groopman studied the efficacy of AZT. Groopman is also currently studying alpha interferon in therapy for AIDS-related Kaposi's sarcoma. In June, Crumpacker reported preliminary results of his investigation of ribavirin at the Second International Conference on AIDS held in Paris. The drug seems to improve immune function and control an AIDS-associated fungal infection of the skin and mouth. □

Rewarding Good Teaching

Anatomists dominated the field of teaching award winners this year. Out of a bumper crop of eight faculty members honored for outstanding teaching, four are members of HMS's Anatomy Department and one is a neuroanatomist at MIT.



Leonard Lilly

Leonard Lilly, Everett Anderson, and David Ryugo were chosen for HMS Prizes for Excellence in Teaching. Lilly, a cardiologist and instructor in medicine at Brigham & Women's Hospital, received the clinical teaching prize. Students called him a "dynamic and committed teacher . . . a gentle corrector, and a thoughtful doctor." Anderson and Ryugo, professor and associate professor of anatomy, respectively, shared the preclinical prize. Students called Ryugo's neuroanatomy course "the most enjoyable and profitable course of the first year," and noted that Anderson, who teaches histology, "used the Socratic method as much as possible," and "encouraged us to ask each other questions and generate the discussion ourselves."

At the Class Day exercises, the Class of '86 gave Richard Murphy



Everett Anderson



David Ryugo

and Frederick Lovejoy Jr. awards for pre-clinical and clinical teaching. Murphy, associate professor of anatomy and cellular biology, was cited as "a teacher who inspires us with humor, knowledge, and creativity." Lovejoy, associate professor of pediatrics at Children's Hospital, was cited as "an enthusiastic teacher and inspiration for another generation of physicians."

The Boylston Society presented its teaching award to Marian Neutra, associate professor of anatomy and cellular biology. She had previously received the Class of 1984's preclinical teaching award.

Steven Weinberger, assistant professor of medicine, won the S. Robert Stone Award for Teaching by a faculty member at Beth Israel Hospital. One student wrote of Weinberger, "I always wanted to learn more and do better for my patients in order to live up to the treatment he gave us."

This year, the Division of Health Sciences and Technology (HST) established the Irving London Teaching Award in honor of its first direc-

Take Heart

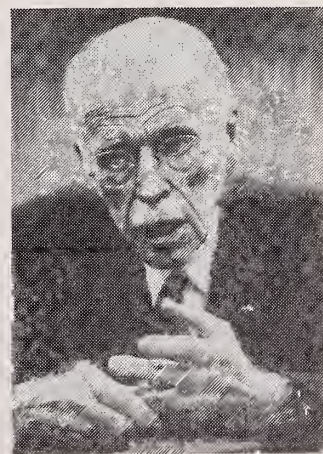
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Walle Nauta

Unique Partnership for McLean

This year Harvard-affiliated McLean Hospital signed a complex agreement with American Medical International (AMI) to form a joint venture company known as McLean Health Services. The arrangement—which provides support for teaching, research, construction, and much-needed renovation—allows McLean Hospital to remain an independent, non-profit corporation governed by the McLean Hospital Board of Trustees.

The innovative solution to the hospital's financial needs came two years after a committee composed of Harvard Medical School faculty recommended against the proposed sale of McLean Hospital to Hospital Corporation of America, an investor-owned company. Last winter the same faculty committee, reconstituted by Dean Tosteson in December 1985 to consider the new proposal from AMI, found that the AMI/McLean agreement contained "adequate safeguards for academic governance at McLean."

The partnership was announced at a February press conference held at the hospital. "It is not a sale; it is not a lease," said Francis de Marneffe, general director of the hospital. The arrangement is intended to strengthen the 175-year-old teaching hospital as a teaching and research institution affiliated with HMS. McLean Health Services will be owned equally by the two partners, operated by an eight-person board of appointees from both institutions, and capitalized with equity investments from AMI and McLean. The new joint venture will develop psychiatric services outside the hospital that will be operated for profit.

Included in the agreement is a guarantee from AMI that the hospital will be able to meet its teaching and research expenses every year, up to the approximately \$2.5 million it currently spends on those activities.

The four McLean-appointed members of the new board are Francis Burr, chairman of the board of Massachusetts General and McLean hospitals; Francis de Marneffe; and George Putnam and Charles Haar, president and trustee of McLean Health Services, respectively. The AMI members are chairman of the board Royce Diener; president and chief executive officer Walter Weisman; senior executive vice-president and chief operating officer R. Bruce

Andrews; and group vice-president and director of program development Robert Diener.

The first priorities of McLean Health Services are the development of programs in community residential treatment, employee assistance, education, and drug screening; contract management of psychiatric units in acute-care hospitals; and physician joint ventures.

The HMS faculty committee report on the AMI proposal predicted that the new arrangement "will provide additional resources to an already strong department." It suggested that the Psychiatry Steering Committee, made up of the chiefs of the six HMS departments of psychiatry at affiliated hospitals, "should be the forum through which the departments assure that the competition among them does not become counter-productive. Program initiatives which will thrive more from collaboration than competition should be coordinated through this group."

The greatest risk, the committee found, could be that "the joint venture will become too strong a magnet for faculty effort if it becomes large and successful. We do not see this risk as a reason to reject the proposal or alter Harvard's relationship with McLean, but we see it as a reason for periodic evaluation of the joint venture and its side effects on scholarship at McLean." Among the report's recommendations were that the dean "charge the Psychiatry Steering Committee to engage actively in its role of promoting and coordinating interdepartmental planning" and monitor the effects of the joint venture on the faculty and programs at McLean through an external review committee.

The advisory committee was chaired by Joseph Martin, HMS Julianne Dorn Professor and chairman of neurology at Massachusetts General Hospital.

AMI is a health-care services company started in 1960 with the purchase of a hospital in Los Angeles. Originally named American Laboratories, the corporation changed its name in 1972 to reflect expansion overseas. AMI now owns hospitals and health-care centers in 20 states and 12 countries outside the U.S., and has contracts with 400 non-AMI facilities for professional and technical services. Among its facilities—ranging from day surgical centers to multi-modality diagnostic centers—are four psychiatric hospitals and 11 substance abuse recovery centers. □

tor. Walle Nauta, MIT neuroanatomist and University Professor, was the first recipient. The student selection committee noted his ability to make a formidable subject enjoyable for a wide audience. Nauta previously received the Boylston Society's teaching award in 1978. □

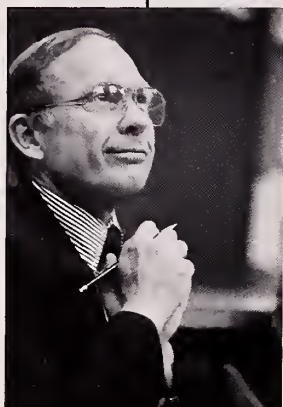


CAMPAIGN FOR THE THIRD CENTURY OF HARVARD MEDICINE

This October, Harvard Medical School officially launches the largest capital campaign in its 204-year history. In the works since the school's bicentennial, the campaign is starting with a nucleus fund of \$55 million raised since July 1983. The fundraising is already having a snowball effect; \$38 million of the nucleus fund was raised in 1985-86. Over the next five years the school plans to meet an ambitious total goal of \$185 million.

On the following pages are the campaign goals, lists of committee members as of August 31, and pieces by three key campaign figures—HMS dean Daniel C. Tosteson '48, Lewis Thomas '37 (co-chairman of the National Campaign), and Daniel D. Federman '53 (dean for students and alumni and co-chairman of the National Alumni Campaign Committee).

LETTER FROM THE DEAN OF THE FACULTY OF MEDICINE



In 1982, the Harvard Medical School celebrated its 200th birthday. At that time, I wrote to HMS alumni in the *Bulletin* about the opportunities and problems facing the school at the beginning of its next century. I write now to invite your participation in the Campaign for the Third Century of Harvard Medicine. This campaign is an essential step toward fulfilling the promise of the opportunities and solving the problems that confront the school.

The sources of the opportunities are the extraordinary people who gather here to learn—people like you, our alumni, each of whom has brought the quality of Harvard medicine to your place of work. Your successors, today's students, are developing the same commitment to serving the sick and suffering, and are building old and new skills and knowledge of medicine, as did you when you were here. They are encouraged and helped by many superb members of the Faculty who are also discovering phenomena and concepts that improve our understanding of the human body. These discoveries, made in laboratories at Harvard and throughout the world, are transforming medicine by providing physicians with ideas, drugs, and devices that are more powerful and effective than ever in curing and preventing disease. I believe that the quality of the new people and new ideas is solid ground for optimism about the third century of Harvard medicine.

As I commented in 1982, there are also problems arising from the gradual constriction in financial aid and physical resources available to support new programs of medical education and research. The splendid marble buildings of the Quadrangle were completed in 1906. Their exteriors, now clad in ivy, look even more distinguished than when I was a student in the mid-1940s. But the laboratories and classrooms within show the ravages of use and time; they require extensive modernization and renovation.

The programs of the school are largely supported by funds raised annually for current use, the sources of which are becoming progressively more limited. Income to sustain the activities of full-time faculty in the Quadrangle and our affiliated hospitals comes from research grants and contracts (60 percent), reimbursement for clinical services (30 percent), and tuition (five percent). Only five percent of annual income derives from endowment, and most of that is restricted to specific purposes such as professorial chairs. This great dependence on funds raised for current use is a strong incentive for faculty to find new sources of financial support for their own work, but it also tends to limit initiative, creativity, and independence.

With these opportunities and problems in mind, we have fashioned a list of the physical and financial needs of the school that must be provided to ensure its continued excellence at the beginning of its third century. This list is not simply the sum of faculty desires. Rather, it is a disciplined statement of priorities compiled by successive filtering of requests advanced by faculty, alumni, and students—and a conservative estimate of the financial requirements for responsible stewardship of Harvard medicine.

The campaign goals are aimed primarily at underwriting programs of education and research carried out by members of the Faculty of Medicine. These programs are administered through HMS, including its affiliated hospitals, the School of Dental Medicine, the Harvard-MIT Division of Health Sciences and Technology, and the Division of Medical Sciences of the Faculty of Arts and Sciences (through which members of the Faculty of Medicine direct the work of students seeking Ph.D. degrees in the sciences basic to medicine).



PHOTOS BY JERRY BERNDT

Campaign goals for the support of research include Funds for Discovery, which will provide endowments for investigations in specific fields of the basic and clinical sciences. One such fund has already been established by David and Julieanne Dorn for research related to degenerative diseases of the nervous system. Income from this fund for discovery is currently financing research on the pathogenesis of Huntington's Disease in the laboratories of Joseph Martin, David and Julieanne Dorn Professor of Neurology and chairman of the Department of Neurology at Massachusetts General Hospital. Other research funds are needed to defray the costs of construction of new laboratories for the Department of Genetics and of renovation of outmoded laboratories in the Quadrangle.

The campaign goals for education include endowments for the New Pathway in General Medical Education, the Harvard-MIT Division of Health Sciences and Technology, the School of Dental Medicine, and Countway Library. The principal construction project in the campaign is the Medical Education Center described in the summer *Bulletin*. We are also seeking funds to complete the renovation of Vanderbilt Hall. Not least, we need to sustain and strengthen our program of financial aid for students.

Since professors at the school conduct research and teach as well, endowed chairs will support the programs of discovery and education. The campaign goals include 18 clinical, 10 basic science, and six social science named professorships.

As you know from my dean's reports and remarks on annual Alumni Days, we have been preparing for this campaign for several years. On October 17, we will announce formally the five-year Campaign for the Third Century of Harvard Medicine that will end on December 31, 1991. We have recruited outstanding staff under the direction of Bill Stone, our enthusiastic and dedicated dean for resources. They have helped alumni, faculty, and students raise a nucleus fund of \$55 million, which gives us confidence that a campaign goal of \$185 million is realistic.

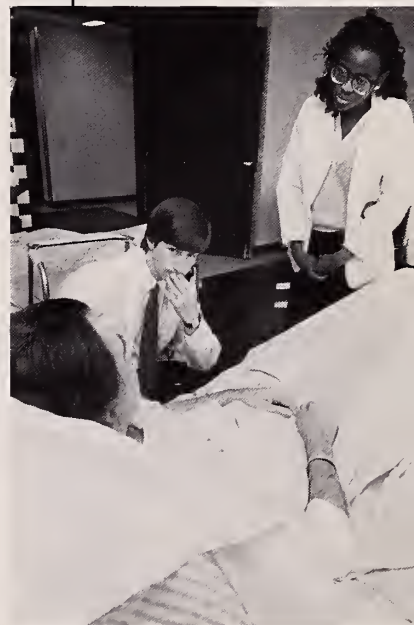
Particularly important for the success of the campaign is its leadership. We are grateful and pleased that Lewis Thomas '37 and Colman Mockler (Harvard College '52, Harvard Business School '54) have accepted our call to become co-leaders of the campaign. Thomas is a distinguished physician, scholar, and writer—a bard of modern medicine. Mockler is chairman and chief executive officer of the Gillette Company, a former chairman of the Harvard Board of Overseers, and a current member of the Harvard Corporation. They will provide advice and sound guidance through their roles as co-chairmen of the campaign and its National Campaign Committee.

We have also formed a National Alumni Campaign Committee composed of alumni from all parts of the country. Its two able co-chairmen, Dan Federman '53 and Perry Culver '41, have long histories of service to the school. Federman has been our dean for students and alumni for the past eight years. Culver was director of Alumni Relations for a dozen years and is now a consultant with the Development Office.

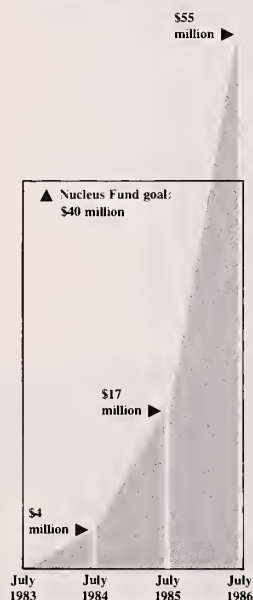
You, the alumni, will play a central role in the Campaign for the Third Century of Harvard Medicine. You know and love your alma mater. Now she needs your help. Naturally, I hope you will make the largest contribution your situation will allow. Whatever the amount of your gift, your participation will send a signal to potential donors that our alumni care about the school. When a fellow graduate calls seeking your help, say "Yes!" You will then be doing what you can to assure that the third century of Harvard medicine will be as glorious as the first two.

—Daniel C. Tosteson '48

This campaign is an essential step toward fulfilling the promise of the opportunities and solving the problems that confront the school.



Nucleus Fund Progress



The campaign nucleus fund started in July 1983 with a target goal of \$40 million by the campaign kickoff this fall. In its first year, the fund raised \$4 million. The following year it quadrupled: \$13 million was raised, bringing the total to \$17 million. In its last and banner year, the nucleus fund soared past the \$40 million goal to a \$55 million grand total.

CAMPAIGN GOALS

Funds for Discovery \$25,000,000

These endowment funds for research will offer support for talented young faculty, Ph.D. candidates, and post-doctoral trainees—and for promising research not yet funded by government, foundations, or industry.

New Pathway in General Medicine \$25,000,000

HMS is in its second year of pioneering an approach to medical education that emphasizes the ability to manage over that of memorizing information. One-fourth of the Class of 1990 is enrolled in the New Pathway; those students and their predecessors in the Class of 1989 are taking part in small-group seminars that integrate traditionally distinct basic, clinical, and social sciences.

Endowed Professorships \$51,000,000

Critical to the future of HMS, endowed professorships—needed in the natural, clinical, and social sciences—give senior faculty research freedom and more time for teaching.

Financial Aid \$16,000,000

HMS helps 80 percent of its students—all who need financial aid—with packages that include loans, scholarships, and work. In recent years, as costs have risen and federal aid has dropped, student debt has risen alarmingly; the average debt at graduation from HMS this year exceeded \$60,000. Campaign funds will help reduce students' debt burdens.

Countway Library \$3,000,000

The largest university-centered medical library in the world, the Francis A. Countway Library was established in 1965 through the generosity of Sanda Countway. Funds are needed for acquisitions and for preservation of one of the world's greatest collections of rare medical books.

Health Sciences and Technology Program \$5,000,000

A joint, multidisciplinary effort of Harvard and Massachusetts Institute of Technology, HST enrolls approximately 25 HMS students a year in a program designed to give them strong quantitative science backgrounds.

Dental Medicine \$5,000,000

Harvard School of Dental Medicine, the first university dental school in the U.S., has for 166

years been a leader in dental education and biomedical research. Its faculty is part of the Faculty of Medicine. Campaign priorities include endowment of a clinical research center, establishment of endowed teaching funds, and renovation of laboratory facilities.

Medical Education Center \$25,000,000

Now under construction in the Quadrangle, HMS's new Medical Education Center is slated to open in September 1987 (see related piece). The center will house almost all of HMS's pre-clinical educational activities—including the small seminars now being pioneered in the New Pathway.

Vanderbilt Hall \$7,000,000

Built in 1926 through the generosity of Harold S. Vanderbilt, the 60-year-old dormitory and facilities are in critical need of upgrading and refurbishing (see related piece).

Quadrangle Rehabilitation \$6,000,000

When the marble Quadrangle buildings were constructed in 1906, they were a marvel of their time. Eighty years later, their rehabilitation is necessary to the research and education missions of the basic science departments at the heart of HMS.

New Genetics Laboratories \$12,000,000

The 16-floor Biosciences Research Building, dedicated in October 1985, was built as a joint effort of Harvard, Brigham & Women's Hospital, and Howard Hughes Medical Institute. HMS's four floors, housing the Department of Genetics, offer approximately 30,000 net square feet designed to accommodate as many as 200 faculty and staff.

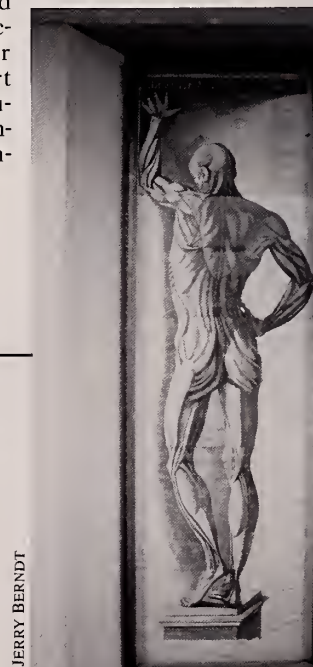
Unrestricted Funds \$5,000,000

Annual gifts for unrestricted use give the school the flexibility to meet pressing needs as they arise. Donors who annually contribute \$1,000 or more for unrestricted use are invited—in acknowledgment of their generosity and support of quality medical education—to become members of the Dean's Council.

Grand Total:
\$185,000,000

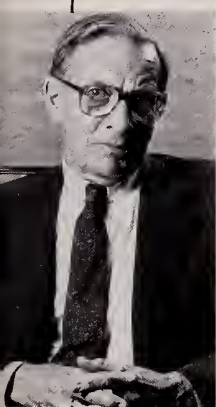


Left: The Quadrangle soon after its 1906 construction. Right: 1781 engraving by Antonio Cattani, on permanent display in Countway Library.



JERRY BERNDT

ON LEARNING TO LEARN AT HMS



EN HASS

It is now a full half-century since I entered my fourth year at Harvard Medical School, confident in the belief that before the year was out I would, somehow or other, have learned everything about everything. It was, at that time, an easy enough prospect. The hospital clerkships lay all around for choosing, each one with a medical luminary seeming to promise the final, essential parts of the whole body of knowledge, just waiting to be fitted together neatly: Henry Christian at the Brigham, Herrman Blumgart at Beth Israel, James Howard Means and Walter Bauer at Mass. General, Fritz Irving and Duncan Reid at the Boston Lying-In— all of these luminaries surrounded by younger teachers who had already mastered the profession. And Boston City Hospital, with the Thorndike Laboratory, any fourth-year student's vision of scientific heaven: Castle, Minot, Keefer, Finland, Dingle, Ellis, Stead, Strauss—a collective textbook of modern medicine. Who could miss? I knew for sure that by the end of that year I would have learned everything

needed for a lifetime.

When the year finally ended, I did indeed know almost everything. But I wasn't quite so sure about that lifetime prospect. Already, my classmates and I could feel the ground shifting under our feet. Medicine was not complete after all, not a finished, coherent set of rules and doctrines, not at all what we thought at the beginning of that year. Of course we knew everything, we reassured one another over late-night poker games in Vanderbilt Hall, but everything seemed to be turning into not all that much.

The next year, during my internship on Four Medical at Boston City, I encountered one of the great differences between a Harvard Medical education and what was learned at other major schools. It was, as it seemed at the time, the difference between inaction and action, between passive skepticism and true belief, between ignorance and total comprehension—and the HMS graduates were on the deprived side of the ledger.

The interns from other schools carried little notebooks filled with instructions for coping with every disease known to medicine; they could explain everything and had a treatment, even long lists of sequential treatments, for everything. We poor chaps from HMS had been brought up to believe in almost nothing, it seemed to us. Nothing, that is, beyond the now deeply-embedded knowledge that we didn't know very much.

Looking back over 50 years, I take this awareness of the limits of our knowledge to have been the unique advantage of a Harvard education, the great gift from HMS that led so many of my generation into research and teaching careers.

At the time, I thought our collective skepticism had been acquired in the last two years of school, in the hospital wards and out-patient clinics. It was only some years later, on reflection, that I realized that the process of doubt and curiosity had begun much earlier, in the first weeks of the first year. In the laboratories and lecture halls of the Quadrangle we had been given the early signals of the full Harvard message—that medicine had come a very short distance in the lifetimes before our arrival, had a long way to go, and, best of all, would almost surely be upheaved by new



JERRY BERNDT

Medicine had a long way to go, my classmates and I learned. The only way round the discomfort of uncertainty would be to keep on learning.

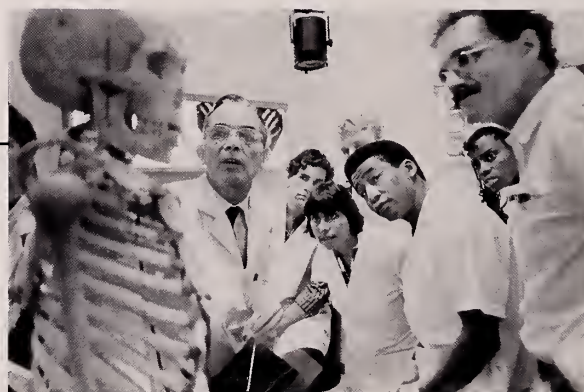
scientific information during our own careers. Uncertainty would be our lot and the only way round the discomfort of uncertainty would be to keep on learning.

This message, as I see it, is still the school's great strength, and its primary source is still the corridors of its buildings—the old ones (with their interiors so redesigned and altered that I can easily get lost between Building A and Building C), and the new ones up and down Longwood and Shattuck. First-year students, roaming the halls, traveling to and from Countway Library, listening to the gossip, bumping into eager-eyed post-docs with heads full of transfiguring illumination, passing worried-looking faculty who seem always to be wondering if anything is *really* true, surrounded by the wildness and strangeness of the new science, may get the idea that medicine is only at its beginning, just getting ready to get under way. The students, if they are as alert and lucky as most HMS students are these days, will feel the tremor beneath their feet and will wonder what on earth they've gotten into.

HMS is still a special kind of school, still busy disturbing the future of medicine, still unique. It remains the best of places to learn about uncertainty, ignorance, and the promise of change. And doubt. And misgivings. And the urgency and permanence of the need to learn.

Mostly because of these enduring qualities of Harvard Medical School, and also because of a deep affection for that dear great place, I am honored and delighted to have a hand in this campaign to keep it going on and on.

—Lewis Thomas '37



PHOTOS BY JERRY BERNDT

UPDATE ON THE NEW MEDICAL EDUCATION CENTER

Construction continues on schedule for the September 1987 opening of HMS's new Medical Education Center, the union of a completely renovated Building E with a new addition. The addition's skeleton, clothed with floors and exterior walls, is now in place, and Building E's third and fourth floors have been gutted in preparation for remodeling into New Pathway administrative space and student evaluation and tutorial areas. Work crews are now renovating the 250-seat amphitheater and installing the skylight over the central courtyard that will be transformed into the commons, the physical and social heart of the Medical Education Center.

The first new teaching facility at HMS since the Quadrangle was constructed in 1906, the center will house most of the school's pre-clinical educational programs. It will include classrooms of varying sizes for small and large groups, quiet study areas, laboratories with adjoining demonstration/lecture rooms, separate anatomy/physiology labs, and an assigned work station for each student. The entire building will be wired so computers and audiovisual equipment can be hooked up almost anywhere and linked in a building-wide network.

The \$25 million project is one of the highest priorities of HMS's Campaign for the Third Century. Due to the pressing need for more and better teaching space and what Harvard president Derek Bok calls HMS's "special dedication to teaching," construction began before the money was raised.

Named gift opportunities include the student evaluation areas, in which student interactions with patients (or simulated patients) can be observed and videotaped through one-way glass; the case-method room (modeled after those at Harvard Business School), designed to encourage discussion and interaction among faculty and large groups of students; the amphitheater; the skylight-covered central commons area, where students and faculty can eat lunch and talk informally, and where the school can hold meetings and dinners when classes are not in session; and the Medical Education Center itself. For more on the new building, see the spring 1986 *Bulletin*.

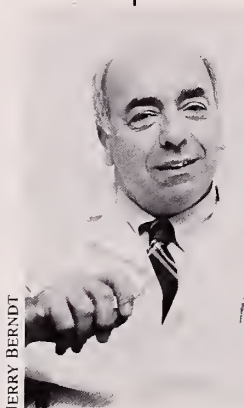


*Above: Dedication of the Quadrangle buildings in 1906.
Below: Artist's rendering of the Medical Education Center.*



ELLENZWEIG MOORE & ASSOC

LETTER FROM THE DEAN FOR STUDENTS AND ALUMNI



JERRY BERNDT

In writing about the alumni role in HMS's Campaign for the Third Century, I'm acutely aware of two apparent paradoxes.

First, of the four billion people on earth, the 7,500 living alumni of HMS are best able to understand and speak up for the nature and value of a Harvard medical education. Yet, by their very accomplishments, many of our alumni are important figures at their own hospitals, or deans and professors in other medical schools, and thus seemingly constrained from active participation in an HMS campaign.

Another paradox is that most capital campaigns depend heavily on wealthy alumni to make major gifts, yet few physicians—and, because of the nature of their careers, even fewer HMS alumni—have the resources for such gifts. The idea that doctors aren't good givers is, however, a misconception. The early experience we have had in preparing for the campaign suggests quite the reverse. Many alumni are committed to the welfare of the school and are proving to be quite generous.

Alumni may be surprised to realize they can make enormous contributions to the campaign beyond their own gift participation. Let me indicate some of the roles I have in mind.

Keeping informed

Knowing and caring about what is going on at HMS is the first move. You can do so by reading the *Bulletin* and *Perspectives*, taking one of the Harvard Continuing Medical Education courses attended by 17,000 physicians each year, or visiting the school during Alumni Week or any other time. Keeping informed will renew your sense of pride in your school and prepare you to give us advice on how to improve. In addition, substantive alumni interest in our activities is enormously heartening to current faculty members and students.

Clarifying the endowment misconception

A lot of people wonder why Harvard, with its large endowment, needs more money. Endowment funds, by their nature, are restricted to special uses. Two of the major goals of the campaign, for example—financial aid and educational innovation—are not nourished by endowment funds.

Speaking up

We want HMS and its capital campaign to be a subject of national attention. No one can speak more informedly of HMS's aspirations and qualities than its graduates who have moved on in their careers to near or distant sites. And the more you stay informed about what's going on now at Harvard, the more you can speak up for the present and future of the school and thus help others understand the need for a capital campaign.

Your roles in your own community or on the national scene are no deterrent to helping in the capital campaign. Indeed, they're strengths. HMS is



JERRY BERNDT



KENDALL DUDLEY

proud that so many of its graduates are primary physicians, chiefs of service, leaders of local clinics, respected regional consultants, chairs of national organizations, and deans and professors. Jim Pittman '52, currently president of the HMS Alumni Association, is dean at University of Alabama Medical School. Dave Challoner '61, an alumni councillor, is vice-president for health affairs at University of Florida. Clem Hiebert '51 is immediate past president of the Alumni Association and new chief of staff at Maine Medical Center. And when Lewis Thomas '37 participated in many of our regional bicentennial activities in 1982, he was president of Memorial Sloan-Kettering Cancer Center. Everywhere, individual graduates are taking excellent care of their patients. Every time one of you speaks up about the quality of research, education, and care that HMS aspires to, you make a contribution to the campaign.

Helping us identify donor prospects

Physicians are valued members of their communities, in a position to influence patients, friends, and other potential donors. The patients and friends of HMS alumni are grateful for the services for which their doctors were partly prepared by Harvard. Enabling such people to make a gift by bringing them together with our Development Office gives grateful individuals a chance to be of service to medicine in general; in a significant way, you are allowing lay people to join you in contributing to the health of the community.

Just within the past two years, patients of HMS alumni have made gifts ranging from \$30,000 to \$1.75 million in *honor* of their physicians. An endowment gift named for the doctor makes that graduate's name a visible part of Harvard in perpetuity.

Giving

Last, we hope HMS alumni will personally contribute to the capital campaign through the Harvard Medical Alumni Fund. Major donors to an educational institution always want to know the level of enthusiasm of its alumni. Individual graduates can strengthen the foundation of the capital campaign both by increasing the participation percentage and by enlarging their personal gifts. In the past, some alumni have chosen not to participate in the Alumni Fund. Now is a good time to re-think one's priorities, recognize the essential role of private medical education in the U.S., and join the special effort to bolster the Alumni Fund.

Now is also the time to consider a major gift. Medical school alumni have many competing loyalties—their college, hospital, national organization, church, and other philanthropies. We fully realize that at any one time HMS may be one of several competing interests for its alumni. But we hope that at this time, only the third occasion in two centuries that we have launched a capital campaign, our alumni will put HMS first on the list for gifts. We hope you will pause, think deeply, grasp the uniqueness of the request reaching you, and make as generous a gift as you can to the Campaign for the Third Century of Harvard Medical School.

—Daniel D. Federman '53



JERRY BERNDT

VANDERBILT HALL REDUX

When Vanderbilt Hall went from dream to reality at Harvard Medical School in the mid-1920s, the Harvard Medical Alumni Association had just woken up to its own existence. Once a sort of local club with annual dues, the association changed policy in 1922 to claim as its members every HMS graduate—and it elected a dynamic new president, diabetes pioneer Elliott Joslin (HMS 1895). Joslin was determined that the association help meet the school's greatest need. That need, it was suggested, was a dormitory—originally the dream of J. Collins Warren (HMS 1863). The efforts of Warren and others to design and raise money for a dormitory after the 1906 completion of the Quadrangle buildings had been interrupted by World War I.

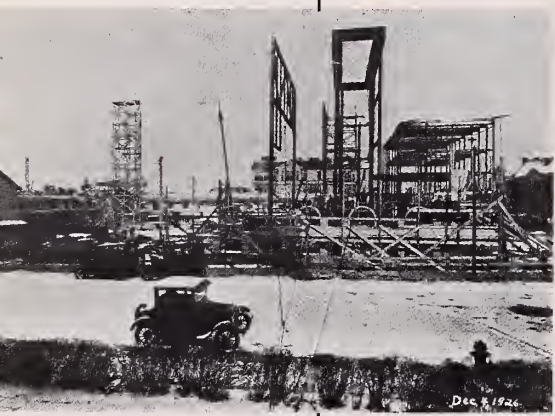
Despite the stumbling blocks of another Harvard campaign, which precluded the possibility of raising money from anyone but HMS graduates for the next three years, and a certain amount of “opposition behind the lines,” as he called it, Joslin forged ahead. The

new building was to be more than a place to sleep; it would attend to the total needs of its residents with a magnificent dining hall, spacious common rooms, a library, club rooms for medical societies, and athletic facilities.

Under Joslin's direction, the association formed committees, divided the country into districts, and approached every one of its roughly 3,000 members. Between the fall of 1923 and the spring of 1925, half the graduates of the school contributed a total of \$113,000. (In the mid-1920s the median annual income of American physicians was \$4,000.) Previously, only 15 percent of the alumni had contributed to Alumni Association activities.

The alumni effort impressed other donors, particularly philanthropist Harold S. Vanderbilt (Harvard College '07), who in 1925 gave \$125,000 for a gymnasium—the first ever in any medical school in the world. He believed that “if students work in an atmosphere of health, they would form habits of health and exercise which would enable them to take care of themselves and be examples to their patients for life.” A few months later, Vanderbilt followed his first gift with a pivotal \$575,000 to complete the campaign. In 1929 the benefactor gave an additional \$450,000 to add more rooms, including the Deanery with its separate quarters.

In its six decades, Vanderbilt Hall has seen year-round occupation during World War II (when 500 men lived in the dormitory, barracks-style), spirited pranks in the early '50s which culminated the

**Living Conditions for Medical Students Are Deplorable**

1360 Graduates have contributed nearly \$100,000 toward a

Harvard Medical School Dormitory Greatly Needed

Gifts from friends together with an investment of school funds, justified by the moderate rentals proposed, make

Half the Cost Already Assured

We believe a dormitory for the Harvard Medical School is necessary and we ask for gifts, both large and small.

There Remains \$555,000 To Be Raised

Please make checks payable to
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DR. FRANCIS M. RACKEMANN
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Executive Committee, Harvard Medical School
Dormitory Fund.

Further information will be given gladly by the Committee.
The cost of this advertisement is an additional gift from a liberal donor.



great tennis court bonfire of 1954, acceptance of six women to live in the Deanery in 1958, and the integration of men and women in all parts of the dormitory in 1972. In its first decades, Vanderbilt hosted meetings of a half-dozen fraternities and clubs (including the Stork and Argo clubs). In the social climate of the 1960s, most of those groups dissolved, and Vanderbilt was the site of the emergence of such groups as the Hamilton-Hunt Association, the Third World Caucus, and the Harvard Public Interest Health Foundation. In 1979, Dean Tosteson established the Cabot, Peabody, Henderson, Cannon, and Warren academic societies, all of which meet in Vanderbilt—as does the Boylston Society, the oldest continuous medical student society in the U.S. The dormitory now hosts meetings of over 30 student organizations—ranging from the Nuclear War Study Group to the HMS Outing Club.

Although given a much-needed facelift in 1979, Vanderbilt Hall is essentially the same structure it was when it was constructed in 1926 and added to in 1929. Sixty years of continuous duty have taken their toll; current needs for handicap access, energy conservation, and essential roof and plumbing work have made renovation of Vanderbilt a major campaign goal for the near future. Particularly cited for improvement are the recreational facilities. Plans call for completely refurbishing the squash and racquetball courts, modernizing the exercise rooms, and relighting the gymnasium. Considerable thought has also been given to the addition of an enclosed swimming pool. A 25-meter lap pool with six lanes would cost \$1,000,000. Although an approved option, the pool is not included in the Vanderbilt Hall Refurbishment Program.

The four-phase rehabilitation program started in the summer of 1985, and is slated to continue through 1989. Work on the roof, windows, piping, and water-heating system will save energy, which in turn will save close to \$50,000 a year. New access ramps and an elevator will serve the handicapped.

Vanderbilt is expected to be an important link with the new Medical Education Center, located a stone's throw away across Longwood Avenue, and a vital component of the New Pathway in its fostering of intense four-year interaction between students and faculty.

Counterclockwise from upper left: Advertisement circa 1925; Vanderbilt Hall under construction; the completed dormitory before the addition of the Deanery; stairway after 1979 facelift; the Deanery in 1958, soon after the first six women moved in (left to right: William Donahue '62, Catherine Minock Wilfert '62, Tenley Albright '61, Lesley Hiller '62, Cheston Marsh Berlin Jr. '62); the Deanery after 1979 facelift.

Pressing needs for handicap access, energy conservation, and essential roof and plumbing work have made renovation of Vanderbilt a major campaign goal for the near future.



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David F. Hickok '56
Minneapolis, Minnesota

James H. Jackson '43A
Brookline, Massachusetts

Ione A. Kourides '67
Forest Hills, New York

William R. MacAusland Jr. '47
Dedham, Massachusetts

Keith Merrill Jr. '44
Manchester, Massachusetts

Henry D. Minot Jr. '50
Norwalk, Connecticut

Mark E. Oren '66
Coral Gables, Florida

John M. Packard '45
Birmingham, Alabama

William P. Peete '47
Durham, North Carolina

Paul H. Pfeiffer '43A
Augusta, Maine

William R. Pitts '33
Charlotte, North Carolina

James M. Rabb '70
Weston, Massachusetts

Richard B. Reiling '67
Kettering, Ohio

Robert L. Replogle '60
Chicago, Illinois

E. Peirson Richardson Jr. '43A
Boston, Massachusetts

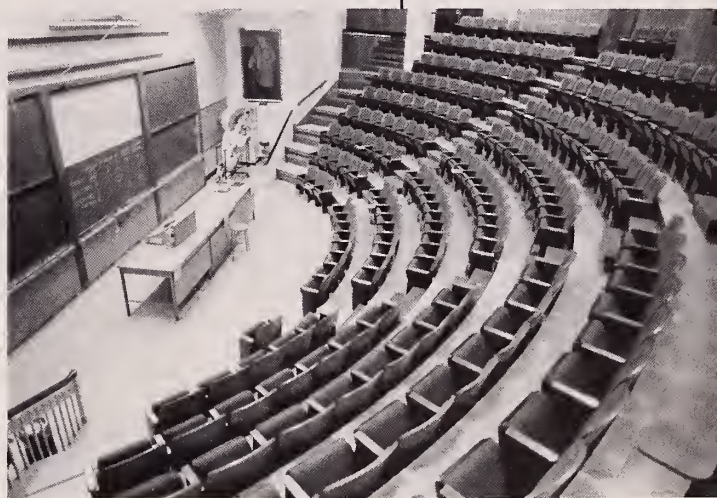
Benson B. Roe '43A
San Francisco, California

Robb H. Rutledge '49
Fort Worth, Texas

Sirgay Sanger '60
New York, New York

John J. Shea Jr. '47
Memphis, Tennessee

William U. Shipley '66
Chestnut Hill, Massachusetts



JERRY BERNDT

Rodman D. Starke '58
San Francisco, California

Claire M. Stiles '56
Palos Verdes Estates, California

Donald N. Sweeny Jr. '40
Grosse Pointe Farms, Michigan

Nathan B. Talbot '36
Brookline, Massachusetts

Jesse E. Thompson '43A
Dallas, Texas

Richard Warren '34
Dedham, Massachusetts

Roy Weatherly-White '58
Denver, Colorado

Stanley H. Wishner '65
Los Angeles, California □





ALUMNI DAY

Only once before in recent memory has inclement weather driven the Alumni Day festivities indoors. In 1967, a nor'easter blew down the tents the day before Alumni Day; this year, a persistent rain soaked tables, chairs, and podium. With some quick early morning maneuvers, Alumni Office staff secured a dry place to meet: Amphitheatre C, where alumni had spent countless hours as students.

For some alumnae, the festivities began two days earlier. In what seems likely to become a new tradition, women HMS graduates held a dinner in

Countway Library. After introductory remarks by Doris R. Bennett '49, each of the approximately 50 women present described her life since medical school. Many talked of their combined roles as doctor, wife, mother, and homemaker. A handful of medical students spoke about their futures. All agreed that the meeting should be held annually and include women medical students.

On Alumni Day, the talks focused on the theme of handling stress. Moderator Ren Zimmerman '61 opened with a description of social changes wrought by the recent exercise fad.

"That wild-eyed, sweaty young man staggering into the bank at noontime in fatigues is not a Libyan hit-man," he said. "He's a corporate vice-president returning from his afternoon jog. And that disheveled elderly woman standing in the park taking bizarre poses is not a bag lady with catatonia; that's your mother-in-law doing T'ai Chi."

Former Olympic gold medalist Tenley E. Albright '61 discussed the continuing health benefits of regular exercise and advised fellow physicians to encourage their patients to adopt healthy habits, particularly early in life. Her classmate and

former lab partner Herbert Benson talked about the relaxation response—the subject of his two books and many articles. Benson is currently at work on a third book, joshed Zimmerman, to be called *Son of Relaxation Response*.

“One always introduces Herb with some trepidation,” the moderator continued, “as his soothing message of good advice has been known to leave more than half his audience prostrate.”

The other two speakers provided Alumni Day firsts. James Oliver '87, first winner of the student essay contest sponsored by the Alumni Association, read his essay, “Social Admit.” Clement Hiebert '51 presented Oliver with a \$1,000 check from the Alumni Council.

Economist David Birch, president of Cognetics (a database company) and director of the MIT Program on Neighborhood and Regional Change, was the first Alumni Day speaker from outside the school and the Alumni Association. He identified the great stresses for the medical profession inherent in coming economic changes, and urged physicians to “conserve” their patients’ health by promoting lifestyle changes.

Adaptations of the speeches can be found on the following pages.

Dean Tosteson introduced two distinguished members of the audience: Lewis Thomas '37 and Karl Menninger '17, both of whom had been honored with Doctor of Science degrees at the university commencement the previous day. Menninger—who received additional kudos as the oldest alumnus present at Alumni Day—is co-founder (with his father and brother) of the Menninger Clinic and the Menninger Foundation. He has pioneered enlight-



Above: Incoming Alumni Council president James A. Pittman Jr. '52 (left) gives outgoing president Clement Hiebert '51 a gift certificate for a set of woodworking tools. Right: Karl Menninger '17.

ened approaches to treatment of the mentally ill, abused women and children, prison inmates, and Native Americans. His Southard School, for disturbed children and research in child psychology, became the model residential psychiatric facility for children. His books include *The Human Mind* and *Man Against Himself*.

Lewis Thomas, president emeritus of Sloan-Kettering Cancer Center and professor at Cornell Medical School, has helped advance understanding of encephalitis, meningitis, and rheumatic fever. He is author of *The Lives of a Cell*, *The Medusa and the Snail*, *Late Night Thoughts on Listening to Mahler's Ninth Symphony*, and *The Youngest Science*.

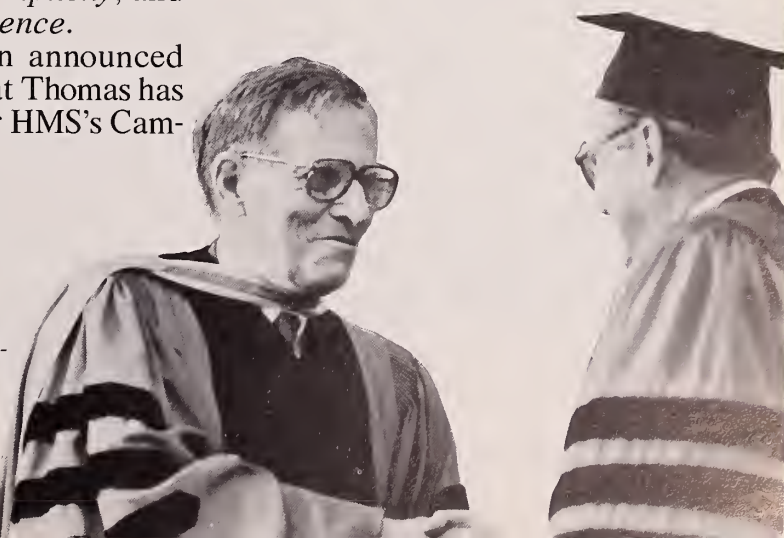
Dean Tosteson announced at Alumni Day that Thomas has agreed to co-chair HMS's Cam-

paign for the Third Century along with Harvard Corporation member and Gillette Company CEO Colman Mockler Jr.

“The campaign can't succeed without the enthusiastic support of the alumni,” Tosteson said. “We need your suggestions and advice.”

The dean touched on some of the highlights of the last year, including establishment of a co-operative program in genetics

Lewis Thomas '37 receiving honorary degree at the university commencement

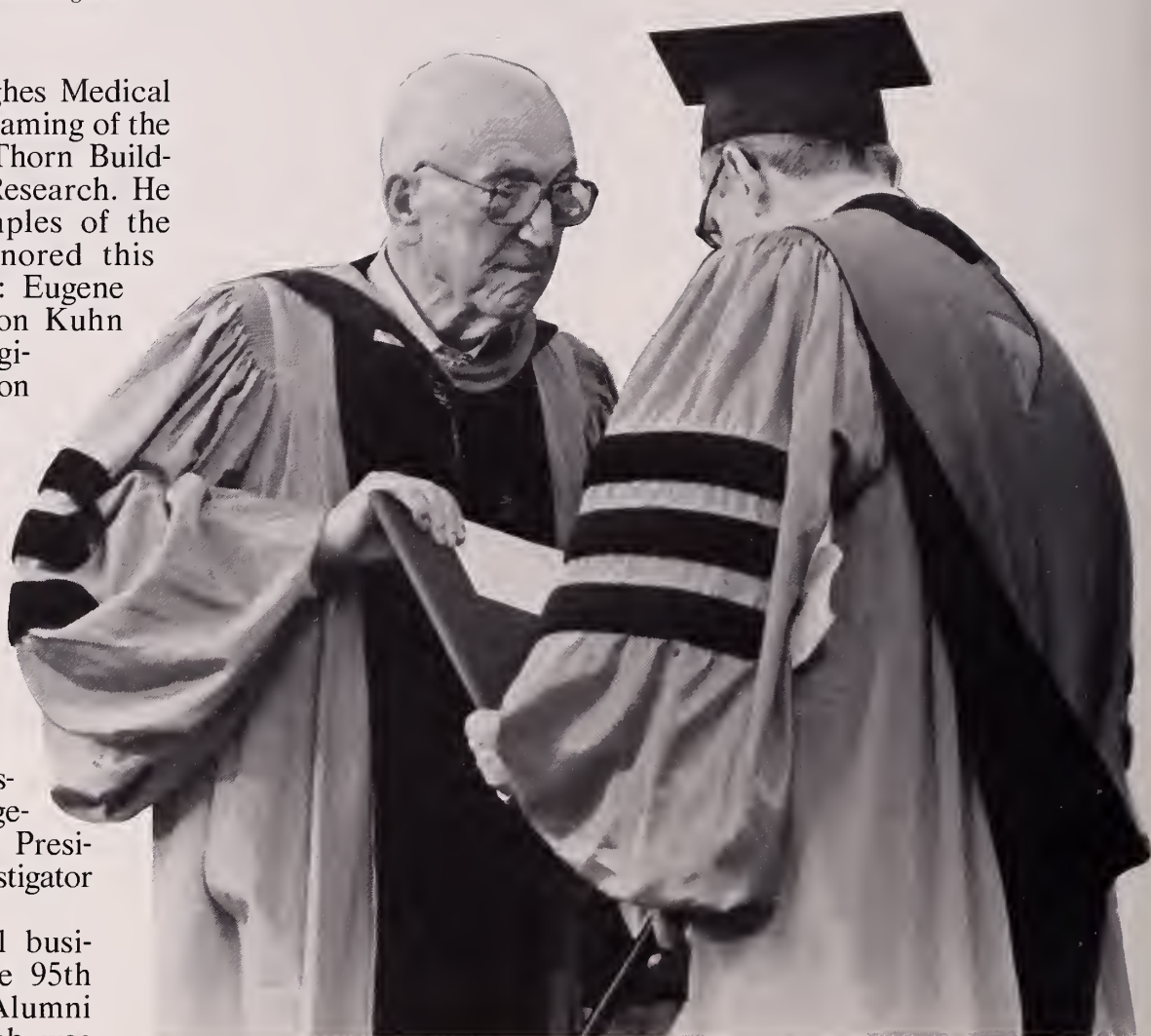


Karl Menninger '17, cited as "a champion of humanity whose medical ministry has brought new hope to the mentally disabled and socially outcast," receiving his honorary Doctor of Science degree

with Howard Hughes Medical Institute and the naming of the new George W. Thorn Building for Medical Research. He cited three examples of the many faculty honored this year with awards: Eugene Kennedy, Hamilton Kuhn Professor of Biological Chemistry won the Passano Prize; Baruj Benacerraf, Fabyan Professor of Comparative Pathology and chair of the Department of Pathology, became a chevalier of the Légion d'Honneur; and Fred Winston, assistant professor of genetics, received a Presidential Young Investigator Award.

At the annual business meeting—the 95th meeting of the Alumni Association, which was founded in 1891—members voted for a constitutional change. The council president will serve as president-elect for two years before assuming office for a year. The arrangement requires two presidents-elect (one elected each year), and eliminates the position of past-president. Other business including the election of Virginia Linnane, longtime administrative assistant in the Alumni Fund office, as an honorary member of the Alumni Association; and presentation of the 25th-year gift—a check for \$32,094.

Joseph Murray '43B, chairman of the Alumni Fund, an-

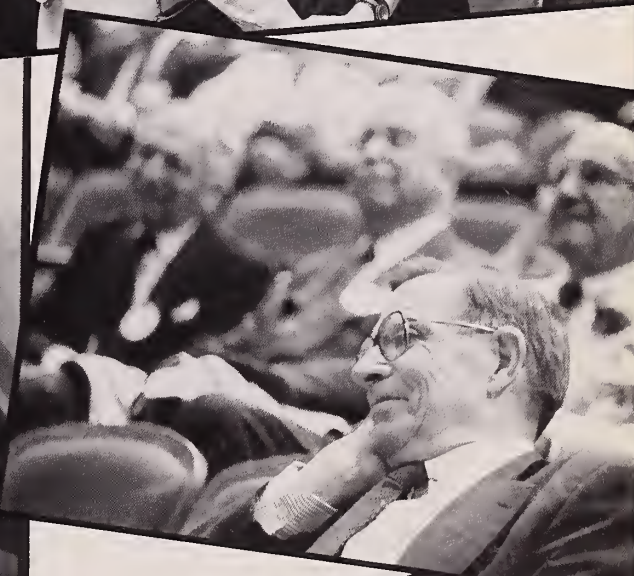


nounced a record-breaking \$4 million in total annual giving to HMS this year, of which \$1.77 million was given by alumni. The Class of 1921 had the highest participation rate, and the Class of 1948 gave the greatest amount: \$300,000. More than 200 alumni joined the Dean's Council by giving \$1,000 or more. An anonymous donor—a grateful patient—gave “a generous six-figure gift” in honor of A. Tillman McDaniel '36.

Clem Hiebert turned over the gavel to James Pittman Jr. '52, who promptly gave his

“presidential address”: stepping up to the podium, he recited his home address in Birmingham, Alabama. The meeting was then adjourned for luncheon, served from tables set up in the main hall and Faculty Room of Building A. Alumni ate picnic-style, balancing their plates as they stood and chatted in small groups, or perching casually on the great marble staircase. Then they went on to participate in perhaps the most important activities of all: the gathering of classmates and renewal of friendships. □

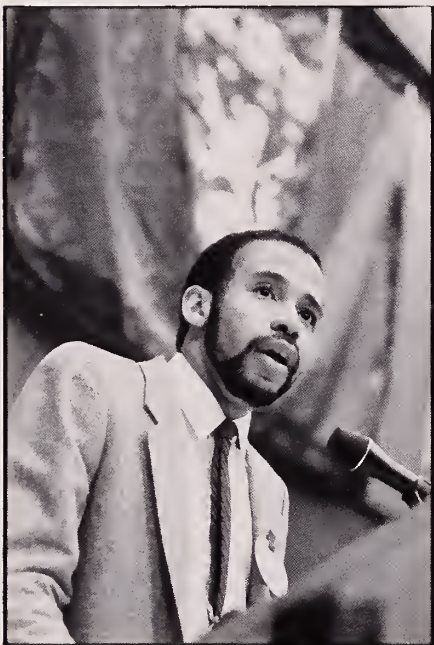
Clockwise from right: Linda Covell Davis '73, Susan Haas '79, and Arlene Sharpe '82 at women's dinner; Lewis Thomas '37 at Alumni Day; Doris Bennett '49 and Claire Stiles '56 at women's dinner; luncheon.



Social Admit

Close encounter of the third year

by James Oliver



One of my first lessons on the wards was the necessity of having interesting cases. The educational worth of a case is a factor, but it pales beside the value of beginning a presentation with the all-important "Ah, yes, this is an interesting case" which guarantees an audience leaning forward in eager anticipation. When you have many interesting cases, you are held in an esteem formerly reserved for the kid on the block with the best set of baseball cards—assured of a choice seat in the cafeteria and endowed with the power to make friends and influence people far beyond the scope of your experiences: "Joe, you had that patient with Tolosa-Hunt syndrome. Can you recommend a good place to go for dinner?"

The adept can find a way to mention their latest interesting cases on rounds and in seminars, over meals,

and at the urinals. If you cannot match others interesting case for interesting case, your reputation is easily consigned to the compost pile of mediocrity; retrieval is difficult.

I had to learn the subtleties of obtaining and showing off interesting cases. Early on, I found out you can't fake it. One day, when all the other cases had been deemed interesting, I didn't want to be left out when my turn came to present. So I blurted out, "Ah, yes, Mr. K., an interesting case," and launched into a totally unremarkable history of a man with chest pains whose doctor had sent him to the hospital for a cardiac catheterization. Everyone snickered behind their clipboards, and I resolved never again to be subjected to such humiliation. I began to lurk about for interesting cases.

Mrs. W. did not qualify. She undoubtedly used to be interesting, but all the diagnoses had been made and all the treatments had failed, and there was nothing interesting left to do for her. She was a social admit, which meant that she was dying in the hospital when the house staff preferred that she die at home. It wasn't that they were unfeeling—it was always sad when a therapy didn't work—but it was an annoying waste of time when a patient could be cared for just as well at home.

Mrs. W. was a 65-year-old female with a carcinoid tumor for which chemotherapy had proven unsuccessful. She had a secondary problem of recurrent intractable facial and jaw pains called *tic douloureux*.

"Carcinoid. Good medical student case," the intern said. "Not really interesting, but then all cases should be interesting to a medical student."

There was nothing particularly unusual about the ways the disease presented itself: Mrs. W. had lost almost all appetite and was having trouble keeping down what she did eat. She

had lost weight and was weak, barely able to climb out of her bed.

"Her problems are entirely social," the intern said. "She's denying the reality of the cancer and so are her children, and they are unwilling to take care of her at home. It's a sad situation, but we come across it all the time. The tic is a bad sign, though. Bet it flares up just when we're ready to discharge her."

Mrs. W. had crinkly, dark chocolate skin wrapped tightly around fragile bones. The skin folded over her sharp cheekbones into the sunken rims of her eyes. Her hairline had receded almost to the top of her skull, and her hair was a shawl of long, wispy strands that were normally worn in a bun. Her hands and feet were too large for the rest of her, and when she moved they swung around like pendulums on tenuous threads. The only place she was not thin was her belly, which bulged up and around as if a bowling ball were trapped inside. Her voice was a tired whisper that just barely slipped past her lips, but her eyes shone brightly; when I first saw them I paused momentarily, because there was a resemblance to an aunt of mine who always had a benevolent smile on her face but never let me get away with anything.

To be honest, we were not certain whether Mrs. W.'s tumor was carcinoid. The diagnosis had been based on a rather inconclusive microscopic evaluation of a tissue specimen from her intestine. She had few of the clinical symptoms associated with the disease. The diagnostic test for carcinoid—analysis of a 24-hour collection of her urine—had never been attempted. This test, like most, is listed in the texts so medical students can look it up and suggest it to their residents, thus giving the resident the opportunity to make clucking sounds and roll his or her eyes at the medical student.

Mrs. W. was always so pleased to see me that it made me uncomfortable. She imparted a sense of expectation, as if I had some secret plan to share with her, and I constantly found myself trying to temper her enthusiasm. She had a well-demarcated, firm 10-centimeter mass on the right side of her abdomen. Every day I came in to feel the lump and listen to her heart and encourage her to eat. She was cooperative about letting me touch the sensitive area, but not about eating.

"Make her eat," the intern said on morning rounds.

I stuck my head in the doorway of the four-bed room. "Hi. Are we eating?"

She grimaced and patted her stomach gently. "Oh, I had a little something. A piece of bread. I didn't feel like having a lot."

I exhaled slowly. "Well, let's try to do a little better at lunch, Mrs. W."

"All right. You're doing a wonderful job, Doctor." She always used this technique to defuse my irritation.

I wrote in her chart: "Patient still refusing nourishment. Plan: placement, social consult." I didn't spend much time with her. She seemed like a nice lady, but I had to find some interesting cases.

It was a dry spell. The really interesting cases, the ones that generated an aura of genuine respect, were hard to come by. There was a renewed spurt of curiosity about Mrs. W. A fourth-year student came by to look at her chart for an endocrinology consultation. ("Carcinoid," somebody had told him. "Good endo consult.") There was a glimmer: maybe, I thought, Mrs. W. can be resurrected into an interesting case. "Should we do a urine 5-HIAA assay on Mrs. W., to make sure of the diagnosis?" I asked the resident nonchalantly.

The resident made a clucking sound and rolled his eyes. "Too much trouble," he said, "and it won't make any difference in her treatment wheth-

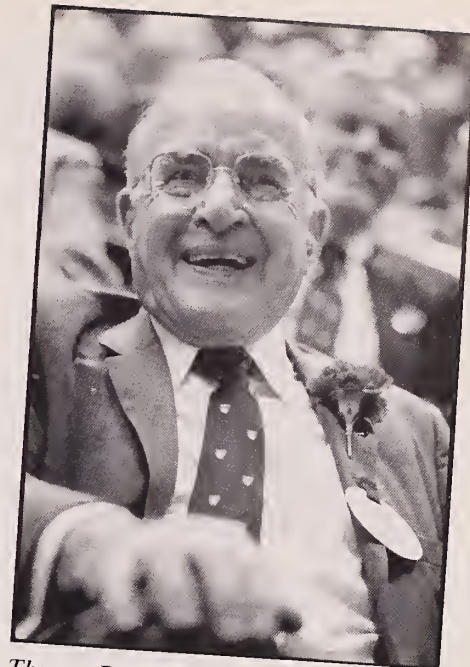
er she's got carcinoid or adenocarcinoma. Just get her to eat so we can get her out of here."

A pathologist reviewed the slides of Mrs. W.'s tumor and decided it was an adenocarcinoma and not a carcinoid after all. Now not only was she uninteresting, she had never been interesting to begin with. The fourth-year student stopped coming by. I intensified my search for interesting cases.

And then it poured. Interesting cases abounded. Leukemias, infections, organ systems run amok. Lab values bouncing up and down with therapies changing daily. I submerged myself in textbooks, squeezing facts in, and I thought, "This is it. This is what it's all about." I was yelled at, criticized, my incompetence rubbed in my face. Everything I knew was not enough, but I learned to say, "Ah, yes, interesting case," with the best of them. My notes on Mrs. W. became even more cursory: "Patient will try to eat bacon tomorrow."

Then late one night I went with the intern to see one of his interesting cases, an elderly woman with assorted gastrointestinal and possible neurological disorders. This woman's granddaughter, a former nurse, was having running arguments with the intern about her grandmother's treatment. Now the granddaughter was upset because a barium enema had been done without her approval. She and the intern went at it in the hallway.

I was left alone in the private room



Thomas Dublin '36

with the patient. She sat in a chair in the corner, a plump, sweet-looking lady in a nightgown, staring into her fidgeting hands with a distant smile on her face. Suspended from the ceiling directly above her glowed the television set, ignored, casting a gray-blue light onto the somber walls. It was pitch dark outside the window; inside, it was perfectly still except for the muffled voices arguing on the other side of the door. I stood looking at the woman with her chart under my arm and my eyes stinging from exhaustion. Suddenly a feeling of convergence swept over me. Here was this sad little woman who was only vaguely conscious of the battle going on outside. Or did she understand and was she just trying to hide her embarrassment over the loss of control over her own life?

I thought about another interesting case a few doors down, a psychotic woman with acute leukemia who was bleeding into every cavity and through every orifice of her body, who threw glass I.V. jars at nurses, but who in her one moment of clarity said, "So this is what it's like to die." Nearby was the drug-abusing 30-year-old with lupus, abdominal bleeding, and bizarre liver function tests who violently cursed me, my ancestors, and my future progeny when I was putting in her nasogastric tube.

What had I learned from these people? What had I done for them? What would I ever be able to do for them? Here I was in a room with another human being, mute because I could think of nothing to say. As I



Somers Sturgis '31 and Meta Tomasch, wife of John Tomasch '31

looked around the room, I focused on that lingering hospital scent that is called "mediciney" for lack of a better word, and I began to realize what it was. It was the sighs of tired old people and the moans of the young, the cries of those unable to do anything else and the silence of those unable to know better. When these people left or died, the cleaning staff tried to wash the smell out, but instead they washed it *in*, and it mixed into an invisible patina with all the previous smells, a haunting mist.

What a terrible place a hospital is to be sick in, I thought. How suffocating and lonely it is at a time when you most need people. I turned back toward the woman and saw that her eyes were moist, and just before she spoke I grasped for the first time how aware she was of what was going on.

"But I told the doctor it was all right to do it," she whispered. I wanted to turn and bolt from the room, out of the hospital and into the warm summer night, but the intern no doubt would have considered that poor form.

The next afternoon, when I went to see Mrs. W., there was an attractive, well-dressed, cheerful woman by her bedside. Mrs. W. introduced her daughter, who worked as a secretary and was married to a construction worker. I was surprised. They did not sound like a family who could not or would not take care of Mrs. W. It turned out that it was Mrs. W. who refused to move in with her daughter because she preferred to be independent.

Cautiously, I tried to determine the extent to which they had come to grips with Mrs. W.'s cancer. How did they feel about the illness?

"We aren't worried about it one way or the other. It's in the Lord's hands." Is this what my intern had meant by denial?

I asked the daughter, "Then why did Mrs. W. come back to the hospital?"

She gave me a look as if to say I should get a refund on all the tuition I had ever paid. "Because she's sick and we don't know how to help her. If we did, we would take care of her. Do you think she *likes* being here? Do you think she *wants* to be here?"

Everything I knew was not enough or it was wrong, and it seemed that mostly it was both.

In the days that followed, I came in and felt Mrs. W.'s mass and listened



to her heart and took her blood pressure. Mostly, though, I talked with her.

"Hi. Are we eating?"

"I don't know what you did this morning, Doctor, but I had a bowl of Frosted Flakes. Are you happy now?"

"That's great. I'm doing a wonderful job."

We spent an hour discussing the merits of butter pecan ice cream and Fig Newtons versus those of orange sherbet and ginger snaps. She liked the Lakers over the Celtics because "that Magic Johnson is such a nice young man." When a physician, trying to determine the mental status of a woman in the next bed, asked her who the president was, from behind her screen Mrs. W. piped up, "Old buckethead Reagan."

"Patient oriented times three," I wrote in Mrs. W.'s chart. Her appetite steadily improved. Once, when things were going well, her tic came on, and my intern shook his head knowingly. But I watched her, curled up, wincing, with her fists pressed against her ears; the pain seemed real enough to me.

Finally Mrs. W. felt well enough to go home, much to the joy of the intern. She thanked me profusely, and all I could do was smile, knowing I hadn't done a damn thing.

I still think about her a lot. She was called a social admit because she did not belong in the hospital. By

that definition I felt like a social admit many times, but she taught me that the years I had spent *not* being a medical student count for something. Besides, I learned that nobody *belongs* in the hospital. There is no logically tenable, medically rigorous explanation for why Mrs. W. came into the hospital and why she left, but I've seen enough by now to believe that specious accomplishments are often as good as you get in this game.

Overworked interns and residents tend to develop a bunker mentality, in which a patient is viewed as a kind of adversary, an exploiter of limited time and energy. So the commonplace, the trivial, the cases with the lowest intellectual return receive the smallest expenditures of effort. This arrangement is generally reasonable and efficient. But when the "uninteresting" case breeds the passing of significant misinformation, even though not related to therapy, something is out of whack.

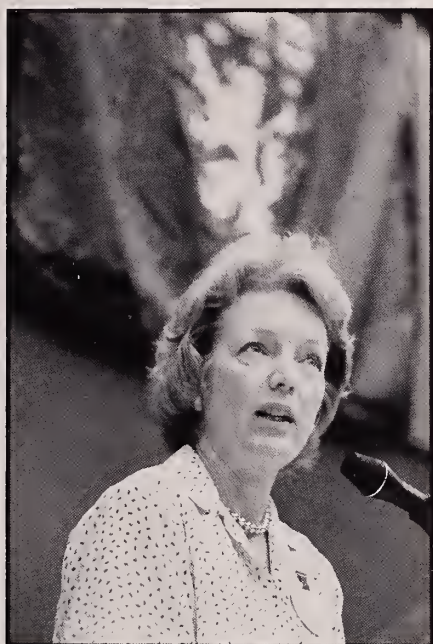
Of course, someday I will be an overworked intern and will have conveniently forgotten all this. I would not be surprised, however, to find Mrs. W. still around, confounding medical wisdom and not letting me get away with anything. After all, we social admits have to stick together. □

James Oliver '87 won the 1986 Student Essay Contest, sponsored by the HMS Alumni Council, with this piece.

Surgery and Healthy People

Lifestyle as preventive medicine

by Tenley E. Albright



Harvard Medical School has changed over the last 25 years. Although the size of this year's graduating class is not much larger than mine, it has eight times more women. This year tuition topped the \$14,000 mark. My father, Hollis Albright '31, recently reminded me that when he was at HMS, the tuition was \$400. For the Class of '61, it was \$4,000.

Members of the Class of '86 graduated with debts ranging from \$3,000 to as high as \$99,100, which they must start paying back on their residency salaries. When we think about those figures, we realize we must do whatever we can to keep the ideals in medicine, the qualities we want to see in the profession. When the Admissions Committee looks at applications (with director of admissions Jerry Foster guiding us intensively—and he makes those meetings a real workout), we realize we're pretty lucky we didn't have to compete with to-

day's candidates. The Class of '86 is certainly outstanding; I can tell you the Class of '90 promises to be super.

Today the Class of '61 has a chance to tell our professors, our teachers, and our mentors, "We listened to you—although at times we looked blank and as if we weren't absorbing anything." Certainly Herrman Blumgart gave us good advice when he said, "Listen to the patient. He may be telling you the diagnosis." Another bit of advice that sticks is, "Get the patient ready *before* you operate."

After all our training, some of us discover the obvious. The obvious to me, as a surgeon, is that a patient is most receptive to suggestions about changes of lifestyle during the post-operative period. Then, perhaps more than any other time, a person is ready for a little advice and guidance about how he or she could have prevented surgery, or might prevent going through it again. We in medicine have an obligation to make the most of that opportunity.

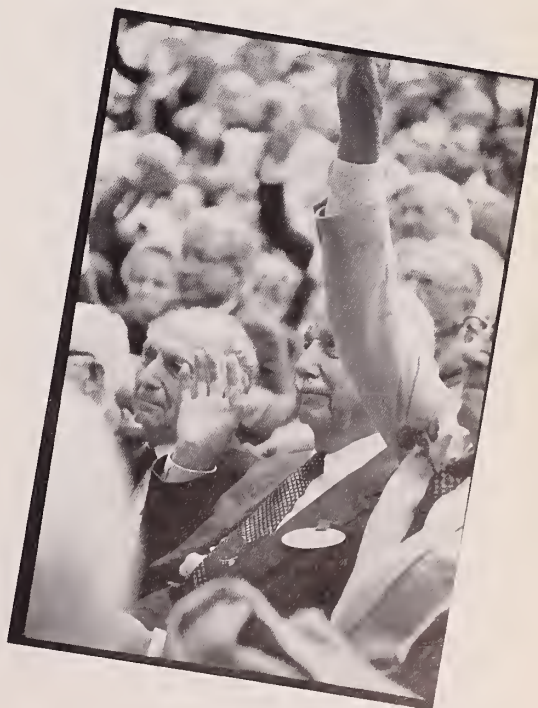
I find that patients are asking more and more questions. They want physicians to guide them. They are ready to take advice, especially as it relates to lifestyle. As we address the avoidable, the changeable, and the preventable, we mustn't neglect the simple and the obvious.

The ultimate positive result of surgery is to restore health, but often the health we restore wasn't so great to begin with. As surgical technologies and less invasive tests advance in astounding strides, differences among individual patients become more and more obvious. It's interesting to try to figure out the factors that influence outcome, morbidity, and perfect healing. As Francis Moore '39 drummed into us, it helps to be healthy as a surgeon, and it helps to have a healthy patient. "Get the patient in balance the best you can before the operation," he advised. "Even in an emergency, take every bit of time you

feel you can to establish the best possible electrolyte balance." Now George Clowes '41 is advising us to pay the same attention to serum protein. A low serum protein can have a dramatic effect on the outcome and prognosis of surgery.

Just when we have so many advanced techniques and so much superspecialization and standardization of medical care that endanger the personalized aspect of medicine, our scientific methods are helping us measure the difference stress makes on health and in complicating illness. We're beginning to understand better factors we have known about instinctively for many years, such as the mind-body connection. We are now able to detect, for example, ACTH receptor sites on leukocytes that are identical to the ones in the neuroendocrine system.

It's interesting to try to figure out if what one does in early life has an effect on one's health. I was part of a team that recently studied 5,398 women college graduates to see if lifestyle during college had an effect on serious illness in later life (Frisch, Wyshak, et al., *British Journal of Cancer*, Dec. 1985). Our subjects were from the classes of 1925 through '81 from 10 colleges across the nation. We were pleased that 71 percent of the women we contacted responded, despite the lengthy questionnaire. We defined former athletes as those who were on a team during college, worked out on a



team at least twice a week, or did the equivalent of running two miles a day at least five days a week. We're not talking about the extremes of world-class levels. We matched the athlete and non-athlete groups carefully to eliminate complicating factors.

We found two and a half times fewer cancers of the reproductive system and one-half the incidence of breast cancers in the former college athletes as compared to the non-athletes. In addition, former athletes had a lower incidence of type II adult onset diabetes and benign tumors of the reproductive tract and the breast. As athletes can experience hypothalamic amenorrhea, which affects estrogen levels that might in turn affect bone density, we also looked at the incidence of fractures in later life. We found that former college athletes had no increase in incidence of fractures in the menopausal and post-menopausal years.

These findings raise more questions. The crisis in medicine today is directly related to economic crises and the cost of running the federal government. Research grants and loans to hospitals have decreased, and in some cases have ceased. Related to these trends is a decrease in the number of independent practitioners. The acceleration of scientific telemetry and of communications and information technology directly affects medicine, just as it does the economy and patterns of political change.

The most obvious way to cut health-care costs is to prevent illness. The statistics on the number of illnesses and operations that could be prevented by changes in lifestyle in earlier life are dramatic. It's crucial for us all to address this issue, so we can help our patients help themselves and help the nation as a whole. And believe me, we need all the help we can get in doing so. □

Tenley E. Albright '61 practices general surgery with her father, Hollis L. Albright '31, and brother, Nile Albright. Winner of an Olympic gold medal for figure skating, she is special advisor to the President's Council on Physical Fitness, founding member of Sports Medicine Resource, officer of the U.S. Olympic Committee, member of the editorial board of the Journal of Physicians and Sports Medicine, and chair of the regional panel of the White House Fellows Commission. She is also the first woman member of the Harvard University Varsity Hall of Fame.

Observations from the Corporate World

The physician's place in the thoughtware economy

by David L. Birch



Medicine is no longer an island. You physicians are being buffeted by world forces, of which the American corporation is one of the biggest. It pays 90 percent of private health insurance, charges you large amounts of money for malpractice insurance, and is increasingly dissatisfied in its relationship with you. I am from that corporate world. Back in 1969 I studied the history of 15 million American corporations; my company is now studying one and a half million in Europe and Canada. Some of our findings have implications for medicine.

We found enormous turbulence in the corporate system. The American economy loses eight to 10 percent of its corporations and eight to

10 percent of corporate jobs every year. It turns over 50 percent of its jobs and firms every five years, a rate that offers enormous opportunity for fast-occurring change. There's been a shift from manufacturing to services, and from the industrial revolution to the information industry. That is part of the change: the American economy has added about 32 million jobs since 1967, yet it now employs fewer people who make things than it did then. This country is essentially going out of the "making" business; today, less than 10 percent of the American work force is directly involved in production.

Most people don't realize that high technology is a small part of the economy; it employs only 2.8 percent of the labor force, and its growth is declining. Over the last three years, technology in Massachusetts has been a fifth of what it was in the previous three years. There's some growth in mature manufacturing companies, but it's largely offset by dying companies.

Virtually all jobs created today in America apply technology to provide services in such diverse fields as computer software, finance, education, telecommunications, consulting, health care, databases, new forms of insurance, distribution, hospital management, and even new forms of trash collection. As this trend is heavily based on thinking and creative innovation, I call it a "thoughtware economy."

One of my best friends made the mistake of buying an oversized garbage truck for his subdivision down in Houston. Soon he had to get a second one. Within 24 months he put together a \$600 million corporation collecting trash all over America in

those big blue-and-white BFI trucks.

Some ask how we can build a great nation by taking in one another's wash and collecting one another's trash. That question misses the fact that we take in the *world's* wash. We sell our wits abroad, to an extraordinary extent—in medicine, education, and computer software. My little company is a good example. The U.S. exports about \$70 billion worth of thought per year for a net positive balance of \$40 billion. Until recently, this country's thoughtware surplus offset its merchandise deficit; Americans have been doing a good job of selling our wits throughout the world for a substantial currency.

In the changing structure of our corporate world, barriers to entry are now quite low and the flow of capital is great; there are tremendous opportunities for innovation and entrepreneurship. Back in 1950, about 90,000 corporations started in the U.S. each year; this year roughly 700,000 sprang up. That figure doesn't include 400,000 new partnerships and 300,000 self-employed workers. Annually, 1.4 million new jobs and 1.4 million new entrepreneurial activities emerge in the United States. In short, for every new job, an enterprise is created.

Our studies found that two-thirds of all jobs were created by firms with 20 or fewer employees and that 80 percent were created by companies with 100 or fewer employees. The Small Business Administration found that from 1980 to 1982, firms of over 100 employees lost 1.7 million jobs while smaller firms created 2.7 million. Though the American economy has grown by nine million jobs since 1980, the Fortune 500 have laid off 2.2 million people. In other words, small companies have created 11 million jobs and larger companies have eliminated over two million.

A Fortune 500 corporation is only 2.5 times less likely to vanish today than a garage start-up. In 1981, 33 percent of the 1970 Fortune 500 had ceased to be on the list and 30 percent had vanished as corporations. These corporations are involved in a global economic struggle which is toppling governments and changing the structure of the world. This struggle creates enormous pressure to control costs and eliminate jobs in order to remain competitive in world markets.

The decline of large companies and the volatility of small, young companies has made the work force unstable. On average, every year in the U.S., one out of five people leaves a

job, one out of 10 is fired, and one out of 10 changes careers. Twenty million Americans are affected every year by these changes.

The fifth-generation computer will replace white- as well as blue-collar workers—and even some doctors. There are packages in medicine and chemistry which I'm sure most of you disdain, despite their dramatically improved usefulness in medical diagnosis. MIT has come up with a computer program that will solve any equation an engineer might face during his or her career. In the financial arena, there's now a package which understands 10,000 spoken English words and can put them in grammatical context and regurgitate them accurately.

Such systems will significantly increase the unemployment rate. It's interesting to think that while in 1945 four percent unemployment was considered excessive, we now accept seven percent as standard. We will come to accept 15 to 20 percent unemployment—the norm in all of Western Europe today—as standard over the next 15 or 20 years.

What does all this have to do with medicine? First, there will be an enormous increase in stress. Many people see their jobs vanishing and feel they're of no value to the economy. The average American is not at all sure that he or she will still be working in the same job next year, and one out of five of them is right. There is a great increase in stress-related medicine, and a huge surge in the psychiatric treatment of stress-related problems in younger and younger people.

The work force's instability also disrupts care and increases cost; employees move from one health plan to the next, and from hospital to hospital, with little continuity or efficiency of care. The biggest sources of your premiums, the large corporations, are dropping like flies. You physicians will be under enormous pressure to lower costs, because the major payers of your fees will be under equal pressure to lower theirs. Corporations have to choose among firing people, losing business to other countries, or paying you less.

I recently visited Cummins Engine Company. The Japanese had told every automobile, boat, bus, and truck company that was a Cummins Engine customer: "We'll produce the same engines for one-third less, and we will deliver them six months from

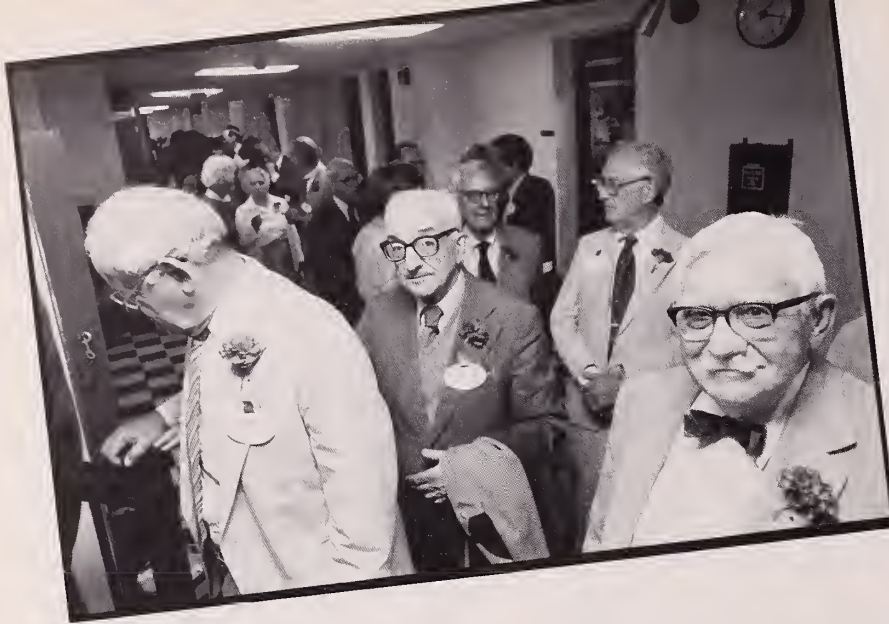
now." In a short time, Cummins Engine had three choices: go out of business, lower everybody's salary by one-third (mainly by decreasing health costs), or fire one-third of their work force on short notice. They chose the latter.

Chrysler's Lee Iacocca has pointed out that the single largest component of cost in an automobile is health care—larger than steel, plastic, or glass. Clearly the first avenue of survival for corporations is going to be to pay you physicians less. They don't care much about quality: they don't know what it means in a medical context. They want to turn health care into People's Express medicine rather than the United Airlines medicine you're accustomed to delivering.

Another consequence of this shift I've been describing is a rapid growth in uncovered employees in the work force. I'm told that 15 percent of the work force is uncovered by any health plan. Many small businesses have no health plans at all, or minimal plans which pay a small percentage of costs. Like it or not, you doctors are running a business. The problems of your corporate partners are becoming your problems.

Assuming you don't wish to voluntarily lower your standard of living, you can either fight or switch. You can resist attempts to lower medical fees with the argument that that would lower the quality of health care. I think you're going to lose that fight. Look at the numbers: 400,000 physi-





Lunch line

cians versus 240 million Americans, 100 million insured workers, and seven million insured corporations. That's like pitting the state of West Virginia against the People's Republic of China.

Furthermore, those 240 million Americans are more organized than they used to be in their dealings with doctors. As recently as 1969, almost half of medical payments were made by individuals; today that figure has halved, and the share coming from organized individuals represented by government or business has risen from slightly over a half to 75 percent. The public and the corporations are circling the wagons and preparing for the battle.

Nor is the sympathy for your cause very great. The average physician in Massachusetts nets \$90,000. That's five times the average earnings of all Massachusetts residents. While I agree that the extensive training and hard work you physicians put in easily justify what you charge, others will argue that their own training requirements have gone up substantially.

The consequences of this struggle over medical costs can already be seen here in Massachusetts. Government-imposed caps on physician charges have reduced the earning ability of physicians in this state to 43rd in the nation. Some 80 percent of HMS graduates will leave this state, partially in response to these caps; the last neurosurgeon has already left Cape Cod. Soon there'll be no place left to run. Corporations are hurting everywhere. Other states will follow Massachusetts. I predict that trade unions and corporations throughout

the country will join together in the struggle to lower health-care costs.

Fighting doesn't look like a promising option for you physicians at this point. On the other hand, switching to health conservation offers great promise. I'm reminded of the energy crisis in the U.S. 10 years ago. When costs became prohibitive, there were but two options: continue with astronomical prices that fueled inflation and lowered everybody's standard of living, or conserve energy and keep prices down. It's clear which path we followed. We consume 33 percent less energy than we did 10 years ago; the consequences can be seen at the gasoline pump today.

I'm told that 75 percent of surgery could be avoided by proper life-time habits, and that 50 percent of all hospital admissions are directly connected to lifestyle—such as habits of obesity, alcohol and drug abuse, hypertension, improper diet, and stress.

Your challenge, if you choose to switch, will be to conserve health, lowering the need for treatment by 30 percent over the next 10 years, as we as a nation have lowered the need for energy. If you can do that, you'll be able to maintain quality and the fee structure for truly critical health needs.

Clearly you cannot make this change alone, any more than the energy industry could. But since you're the ones who know about diet, stress, fitness, and the consequences of tobacco, drugs, and alcohol, you have to persuade the rest of us that we can radically reduce our hospital costs if we take modest steps to live properly. I believe the corporations and trade unions could be persuaded to join you in your quest for health conservation. We must work together to keep the number of health-care travelers down if we want to continue flying the Friendly Skies. □

David L. Birch, an economic microscopist, is president of Cognetics, Inc., an information sciences company, and director of the MIT Program on Neighborhood and Regional Change. He received his A.B., M.B.A., and D.B.A. from Harvard.



The Relaxation Response

How to lower blood pressure, cope with pain, and reduce anxiety in 20 minutes a day

by Herbert Benson



The definition of the relaxation response has its roots in the work of physiologist Walter B. Cannon (HMS 1900) at Harvard Medical School early in this century. As HMS alumni well know, Cannon defined in cats what he came to call the fight-or-flight response, often called the emergency response or the defense alarm reaction. The elicitation of this response increases metabolism, blood pressure, heart rate, and skeletal muscle blood flow. Its "purpose" is to prepare the animal, Cannon reasoned teleologically, for fighting or running. Later, Nobel-Prize-winning Swiss physiologist Walter Hess found, also in cats, that when certain areas of the hypothalamus were electrically stimulated, the response described by Cannon was replicated.

We humans have this response within us—as shown by Czech phys-

iologist Jan Brod, who measured physiologic changes in healthy medical students. After he took baseline measurements, he reportedly said to his subjects, "I want you to do a simple task. I'm going to give you a four digit number, like 9,632. From that number subtract 17; from the new number, in turn, subtract 17; and go on as quickly as you can."

"Furthermore," he instructed, "don't be bothered by a metronome clicking in the background. Nor should you be bothered by your fellow medical students, who will give you encouragement." The encouragement took a form one can well imagine. Within several seconds of the stimulus, the subjects exhibited the physiologic manifestations of the fight-or-flight response: increased blood pressure, heart rate, and a 300 to 400 percent increase in skeletal muscle blood flow.

Many believe our world could be the most stressful in which man has ever lived. Not too long ago the average age of life was 40; half of the children died before the age of five; and plagues and pestilence were ever present. But there was a certain predictability to life. Although people didn't know when a stressful event would reach them, they had a reasonable awareness of what could affect them. We now live in a markedly unpredictable world, where one doesn't have to look far for stressful stimuli that lead to the fight-or-flight response. They come not only from our work and family situations, but also from the news media, where, if it's not a Chernobyl, it's a space shuttle blowing up, or a random poisoning of a common medication. The credo of one of Boston's prominent news stations is "if it bleeds it leads."

The fight-or-flight response is believed to be related to a number of disorders. It's been implicated in hypertension, anxiety, various pain syndromes, and the exacerbation of other already-existing diseases. What then can we do to protect ourselves against the harmful effects of stress?

Hess, when he moved his electrodes slightly within the hypothalamic regions of cats' brains, elicited a reaction opposite to the fight-or-flight response that was associated with decreased blood pressure and respiratory rate. He called it, and I quote him in translation, "a protective mechanism against overstress." We came upon this type of response in humans roughly 20 years ago, when I was fortunate to be working in the Harvard laboratories of Clifford Barger '43A and Peter Dews, along with Alan Herd, Roger Kelleher, and William Morse. Using operant (bio-feedback) techniques, we were able to train monkeys to lower and raise their blood pressures.

While these experiments were going on, several young people came into the laboratory and said to me, "Why are you studying monkeys; why don't you study us? We think we can lower our blood pressure; we practice transcendental meditation." It was 1968, and we were having trouble convincing colleagues that behavior might be related to high blood pressure, so I told these people to go away. They wouldn't. Day after day they returned, insisting on being studied, and I finally agreed.

These were days before institutional review (human studies) committees were mandated, so we sim-

ply took the volunteers upstairs in Building C and made measurements. About the same time in California, physiologists Robert Keith Wallace and Archie Wilson were doing similar studies. By pure chance our experimental designs were virtually the same. Wallace later came to join me at Harvard. We were able to collate and extend our data and thus define the physiology of meditation.

We applied various measuring electrodes and introduced intravenous and intra-arterial catheters to young, healthy, trained meditators and had them sit quietly for an entire hour before taking any measurements. Then we asked them to continue to sit quietly for the next 20 minutes, while we took our baseline measurements. At that point we asked them to start meditating. They only modified their thought patterns. As we made measurements for the next 20 minutes, there was no change in their activity, no change in their posture. After that we instructed them to return to their regular mode of thinking—again they only altered their pattern of thinking—and we made measurements for 20 more minutes.

We found dramatic changes. There was a 16 to 17 percent decrease in oxygen consumption within three to five minutes after the

thought pattern changed to meditation, and it lasted as long as the pattern was maintained. Then the oxygen consumption returned to normal. This finding was paralleled by a similar decrease in carbon dioxide elimination, which indicated that the subjects' respiratory quotient hadn't changed. They were neither holding their breath nor hyperventilating to bring about the changes. There was also a decrease in their respiratory rate; a decrease in their minute ventilation (the amount of air moving in and out of lungs); and a precipitous reduction in their arterial blood lactate (high levels of lactate are often associated with states of disquiet and anxiety, low levels with peace and tranquility).

We asked ourselves whether this state might be reflecting a hibernatory-type response, as there are few conditions, for example sleep and hibernation, in which oxygen consumption decreases from a baseline of rest. A good way to differentiate sleep from hibernation is rectal temperature. A hibernating animal decreases its rectal temperature several degrees, a sleeping animal several tenths of a degree. Bears don't hibernate—as was established by two intrepid physiologists who, in midwinter, armed only with rectal thermometers, entered

bears' caves and made measurements until they awoke one of their subjects. Understandably irate, the bear chased them from the cave. They escaped unharmed, at which point they felt their debt to science was paid and they reported their results in medical literature.

For obvious reasons, I'm fond of that story. About 10 years ago at the Communicable Disease Center in Atlanta, the chief of the U.S. Public Health Service Information Service came to me after my talk and said, "Herb, that story's absolutely true, but you left out one of the best parts."

I asked, "How's that?"

He said "Well, the two physiologists were brothers, and I knew one of them. Their subjects were grizzly bears—tall, stinking, ferocious, top-of-the-ecological-tree creatures—and the study was carried out in Alaska. After trekking through the wilds to find the dens of these brutes, the two investigators were chagrined to find that most of the bears spent the winter sleeping sitting up.

"Thus, they had a logistic problem. But they knew that bears love sweetened fruit. So they secured several quarts of maraschino cherries at a nearby Air Force base and put them in an open basin which they placed in front of the bears. When the bears leaned forward, the brothers made their measurements."

I've been unable to verify the latter part of that story. But under much less hazardous circumstances we measured the rectal temperature of those practicing transcendental meditation and found no change. The physiologic changes are not those of hibernation or of sleep. The EEG changes, the time course of the metabolic changes, and the metabolic changes themselves are different.

We felt we might be recording the physiologic changes of a state that is the counterpart to the fight-or-flight response: the state Hess had described. If so, it made no sense to hypothesize that transcendental meditation was the only way to elicit this response. It would be akin to saying there's only one way to evoke the fight-or-flight response.

We spent several years searching the religious and secular literatures of the world to look for corollaries for the four steps of transcendental meditation (sitting quietly in a comfortable position; closing one's eyes; repeating a word, sound, prayer,

How to Elicit the Relaxation Response

- 1) Sit quietly in a comfortable position.
- 2) Close your eyes.
- 3) Deeply relax all your muscles, progressing from your feet to your face. Keep them relaxed.
- 4) Breathe through your nose. As you breathe out, say the word "one" silently to yourself.
- 5) Continue for 10 to 20 minutes. You may open your eyes to check the time, but do not use an alarm. When you finish, sit quietly for several minutes, at first with your

eyes closed. Do not stand up for a few minutes.

- 6) Do not worry about achieving a deep level of relaxation. Maintain a passive attitude and permit relaxation to occur at its own pace. When distracting thoughts occur, don't dwell upon them, but return to repeating "one." With practice, the response should come with little effort. Practice the technique once or twice daily, but not within two hours after any meal, as the digestive processes seem to interfere with elicitation of the response.

or phrase; and passively disregarding other thoughts). We found the steps in virtually every culture of man.

One early example came from the *Upanishads*, dating back to the sixth century B.C. To attain a union with God, the treatises instruct, pay attention to your breathing and on each out-breath repeat silently to yourself a word or phrase from the *Upanishads*. Should other thoughts come to mind, passively disregard them and return to the repetitions.

Another example came from Judaism, dating to the time of the Second Temple, which is roughly from the second century B.C. to the first century A.D. In a school of thought called Merkabalism, people squatted in a fetal-like posture, rocked from heel to toe, and on each out-breath repeated over and over again the name of the magic seal.

Yet another came from Christianity, and dated to the time of Christ himself. Prayers were passed on by word of mouth through the monasteries and ultimately codified in the 14th century on Mt. Athos in Greece where, to this day, there are hallowed Greek Byzantine monasteries. The instructions were to sit quietly; pay attention to one's breathing; on each out-breath repeat the prayer "Lord Jesus Christ, have mercy on me." Should other thoughts come to the mind, the practitioner was to passively disregard them and return to the prayer. This prayer, currently called the Jesus Prayer or the Prayer of the Heart, has survived into modern Catholicism, modern Episcopalianism, and Presbyterian thought.

In Islam, virtually the same process is called "Dhikr." In Zen Buddhism people kneel, pay attention to their breathing, and count out-breaths in magical numbers—out-breath one, magical number one, out-breath two, magical number two—up to 10 and then back to one again. They disregard other thoughts when they come to mind. Tibetan Buddhists often use prayer beads, walking throughout the day saying the prayer "Om mani padme hum" over and over again. The steps are virtually the same in Shintoism, Taoism, and Confucianism. Only the words are different. In the so-called primitive, shamanistic religions people achieve the same state by chanting to the time of the beating of a drum or the stamping of feet.

Outside of religious traditions we found the same instructions. In England, Wordsworth beautifully described one technique in his poem

"Reflections by Tintern Abbey," in which he gazed at light as it shimmered off of the nearby waterfall. Alfred Lord Tennyson liked himself enough to walk down to the beach and repeat his own name over and over again!

We reasoned that we could replicate the changes by borrowing heavily from any one of these techniques. In our laboratory we gave slightly modified instructions from Zen to young students from Harvard, Boston College, and Boston University. We told them to sit quietly, pay attention to their breathing, and count their out-breaths, disregarding other thoughts. The experiment was a complete failure. The "bright" students lost count, panicked, and that was the end of the experiment. We said, "O.K., stay with the number one." The resulting physiologic changes were indistinguishable from those we had recorded with transcendental meditation.

We next studied religious people who prayed regularly, and found that as long as a prayer was repetitive—in Catholicism a rosary or a Hail Mary-type prayer, in Judaism a davening-type prayer—our subjects went through the same physiologic changes. These results should not in any sense be interpreted as a scientific or mechanistic explanation of prayer. Rather, I interpret them as a reaffirmation of what religious people have been telling us for thousands of years: prayer is good for you.

The next step was to take this mind/body technology back to the clinic. Over the last decade, we've found that the regular elicitation of the relaxation response can be used as a treatment for high blood pressure and other disorders related to the hyper-arousal effects of the fight-or-flight response. Systolic blood pressure decreases in the range of five to 15 millimeters of mercury, diastolic five to 10 millimeters of mercury. These changes are not limited to the time of actually eliciting the relaxation response. The mechanism is believed to be related to decreased responsiveness to plasma norepinephrine. Techniques that elicit the relaxation response are recommended

by the National Institute of Health as therapy for hypertension, along with with salt restriction and weight loss.

The elicitation of the relaxation response is also useful for treatment of virtually all forms of pain. About 60 percent of those with migraine headaches who use relaxation-response techniques have fewer and less severe headaches. Those with more persistent and more lasting kinds of pain, such as low back pain or the pain of cancer, find that although the pain remains, it bothers them less. The symptoms of anxiety, including nausea, vomiting, constipation, diarrhea, short temperedness, and insomnia can be effectively treated by this mind/body interaction.

In essence, we have within us a response that's the opposite to the fight-or-flight response. Its elicitation integrates mind and body, and its study bridges many disciplines—medicine, neurology, psychiatry, and psychology. The response also carries us closer to bridging medicine and religion. □

Herbert Benson '61 is associate professor of medicine and director of both the Division of Behavioral Medicine and the Hypertension Section at Beth Israel Hospital.





CLASS DAY

The operative spirit of Class Day '86 was spunk—from the swinging musical interlude to the effect on the crowd of the torrential rains. The on-and-off downpour—so strong that at times it seemed to threaten the survival of the tent sheltering the ceremonies—served as punctuation for the speeches, and brought the audience close together as outlying onlookers scurried for cover.

Three student speakers supplied humor, thanks, and sober reflection on the social climate in which their careers are starting. During Bill Thomas's talk on the seven ages of the

medical student (with audience participation for his recurring chant "one age done, another begun"), the tent darkened ominously. Albert Maguire next spoke on coping with fast-paced changes in medicine. As he pointed out that "acquired immune deficiency syndrome" did not exist as a term when the Class of '86 started at HMS, a spectacular rain hit the tent. When Roger Mosesson listed experiences that helped him get through his years at HMS, cheers went up from his classmates.

Guest speakers Ronald Arky and Lawrence Altman both spoke of giving attention to fun-

damental values in the face of technological and social change. Many elements of caring for the patient, argued Arky, have changed little in the 60 years since Francis Peabody's essay "The Care of the Patient." Altman discussed the meaning of accountability, and stressed the importance of communication between doctor and patient.

Adaptations of the five Class Day talks appear in the following pages.

The Testostertones—featuring Michael Miller, Lee Learman, Christopher Austin, John Puskas, and Charles Lowenstein—performed rousing renditions of "McNamara's

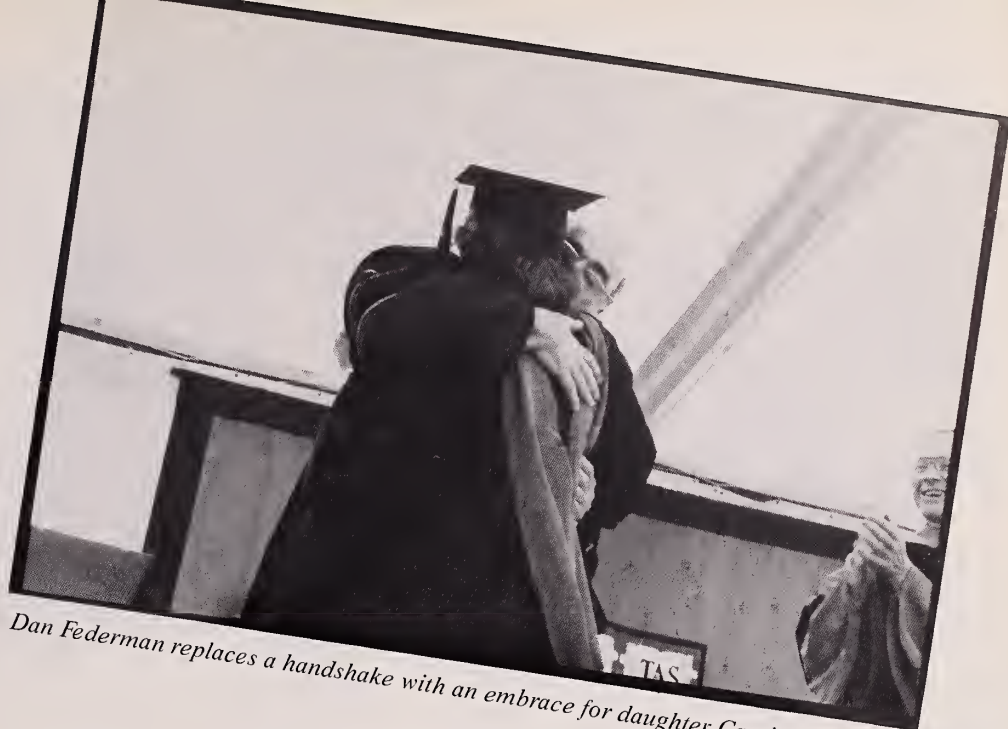
Band" and "Fascinatin' Rhythm." Class Day moderator William Abraham recalled that the group's impromptu performances "were the highlights of our first two years. We never knew when they would turn up and sing." The class joined in for "Shine that Light," written by classmate Scott Solomon.

Following a tradition started two years ago, faculty members selected by the class helped arrange hoods as graduates lined up to receive their diplomas. Martin Samuels, associate professor of neurology, and Curtis Prout, associate clinical professor of medicine and assistant dean for Student Affairs, were chosen this year to do the honors.

In a moment that will certainly stand out for Daniel Federman '53 from all others in his past and future duties as dean for students and alumni, Dean Tosteson stepped aside to allow Federman the honor of handing his daughter Carolyn her diploma. Father and daughter replaced the usual handshake with an embrace.

In his valediction, Dean Tosteson chose one idea ("the wholeness of human being"), one skill ("the ability to observe"), and one attitude ("responsibility,") that he feels are important for all HMS graduates. "Keep thinking about the knowledge, skills, and attitudes that all doctors should share," he urged the class. "Perhaps we can share notes from time to time. It is important not only for your maturation as physicians, but also for the continued refreshing of our program of general medical education at Harvard."

The Class of '86 honored two teachers, Richard Murphy and Frederick Lovejoy Jr., with awards for pre-clinical and clinical teaching (see Pulse in this



Dan Federman replaces a handshake with an embrace for daughter Carolyn

issue). Registrar Noreen Koller, who was unable to attend the ceremony, was also honored ("in appreciation of her cheerful patience and tireless efforts on our behalf")—and the class handed out a certificate of appreciation ("for support and encouragement during our years of medical school") to Valerie Abrahamsen, administrative assistant in Student Affairs.

Thirteen students graduated cum laude in a special field; three graduated magna cum laude in a special field. Ten were honored with prizes and awards.

Pamela S. Becker, Harold Lampert Biomedical Research Prize for the best paper reporting original research in the biomedical sciences: Studies with Dr. Samuel E. Lux on structure and function of spectrin in hereditary spherocytosis.

David A. Benaron, cum laude: "Improving Outpatient Compliance with Medication Regimens Utilizing Electronic Dose Response Priming." Dr. Sirgay Sanger Award for excellence and accomplishment in research, clinical investigation, or scholarship in psychiatry: "Sexual Practices and Beliefs of Second-Year Medical Students" (with Nancy L. Brown).

Registrar Noreen Koller (in 1985), honored in absentia this year by the graduating class

Nancy J. Brown, cum laude: "Mechanism of Bile Salt-Mediated Transport of Insulin Across the Nasal Mucosa."

Nancy L. Brown, Dr. Sirgay Sanger Award for excellence and accomplishment in research, clinical investigation, or scholarship in psychiatry: "Sexual Practices and Beliefs of Second-Year Medical Students" (with David A. Benaron).

Mark S. Cohen, magna cum laude: "Slipped Capital Femoral Epiphysis: The Determination of Femoral Anteversion and Slip Severity by Computerized Tomography."

Anthony M. DiGioia III, cum laude: "The Role of Interfragmentary Strain in Fracture Healing."

Jean R. Elrick, magna cum laude: "Effects of Increased Ionized Calcium on Left Ventricular Functions in Neonatal Lambs."

Robert A. Flores, Kaiser/National Medical Fellowship Merit Award for outstanding



ing academic achievement by a graduating minority medical student.

Joseph S. Friedberg, cum laude: "Human Small Bowel Transplantation into Athymic Animals."

Shelly F. Greenfield, cum laude: "Health Beliefs and Compliance."

Mitchell H. Katz, Richard C. Cabot Prize for the best paper on medical education or medical history: "The History of the Medical Response to Child Abuse, 1940-1980."

Kenneth M. Kaye, cum laude: "The Genetic Basis for the Altered Pathogenesis of an Immune-Selected Antigenic Variant of Reovirus Type 3 (Dearing)."

Robert A. Kersh, cum laude: "Experimental Use of Human Recombinant Tissue-Type Plasminogen Activator in a Rabbit Model of Surgical Microvascular Repair."

Kihan F. Lee, Rose Seegal Prize for the best paper on the relation of the medical profession to the community: "Medical Liability Law, 'Malpractice Crisis,' and Physician-Patient Relationship."

Alan M. Michelson, James Tolbert Shipley Prize for research, the results of which have been published or accepted for publication: Studies with Dr. Stuart H. Orkin on the human phosphoglycerate kinase multigene family.

Stephen T. Onesti, cum laude: "Somatostatin Immunocytochemistry in the Rabbit Retina."

Daniel S. Ory, cum laude: "A Restriction Map of the Human Growth Gene Family."

Michael A. Pollack, magna cum laude and Henry Asbury Christian Award for notable scholarship in studies or research: "Computer Support for Diagnostic Test Selection Through Educational and Analytic Pictorial Simulations."

Michael A. Quinones, cum laude: "The Synthesis of a Novel Amino Acid, 4-amino-5-cyclohexyl-2, 2-difluoro-3-hydroxypentanoic Acid and the Synthesis of Two New Potent Renin Inhibitory Peptides in the Subnanomolar Range."

Jean E. Schaffer, cum laude: "Functional Analysis of ORI_L. A Herpes Simplex Virus Type I Origin of DNA Synthesis."

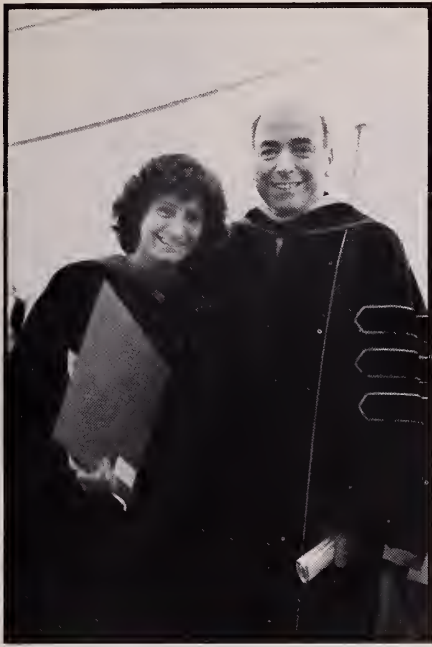
W. Robert Taylor, cum laude: "Relative Airway and Parenchymal Hysteresis in Asthmatic Subjects."

James R. Wong, cum laude and Leon Reznick Memorial Prize for excellence and accomplishment in research: "Mechanism and Activity of a Novel Class of Anticancer Chemotherapeutic Agents: Lipophilic Cations."

Terri L. Young, Kaiser/National Medical Fellowship Merit Award for outstanding academic achievement by a graduating minority medical student. □



Moderator William Abraham hands awards to (from top): Valerie Abrahamson, Frederick Lovejoy Jr., and Richard Murphy



Clockwise, from above: Carolyn Federman '86 and Daniel Federman '53; Abbott Miller '57 and Michael Miller '86, the Testertones; Ramzi Cotran, professor of pathology, and Paul Cotran '86

The Seven Ages of the Medical Student

A refrain for our times

by William H. Thomas '86



In Shakespeare's day, seven ages consumed an entire lifetime. Our class has already lived seven ages. One after another—through the years of work, the love and support of our families, friends, and teachers, and the joy of seeing our dreams come true—they led us to this place and this day.

The first age was played out long ago. Today only our parents can remember the members of this black-robed class as babes in arms, clad in white diapers and crying for milk. All that remains to remind us are the yellowing photographs on the front pages of our family albums.

One age done; another begun.

Then the longest journey. In the second age, we played the schoolchild with shining morning face. We passed from finger painting to French literature, from skinned knees to broken hearts. We grew from childhood to adulthood and left our families' homes.

One age done; another begun.

Then the highest drama. In the third age, we played the premed. Singing woeful ballads as we labored, we lived under the blade of uncertainty until that first acceptance letter set us free.

One age done; another begun.

Then the deepest drama. In the fourth age, we played the pre-clinical student. Incarcerated in the lecture hall, manacled to our textbooks, we saw no patients, heard no patients, and touched no patients. Despite all our work, we felt no closer to being *real* doctors than when we arrived.

One age done; another begun.

Then the greatest apprehension. In the fifth age, we played the bumbling student. Using our starched coats and expensive stethoscopes to cover our inexperience, we struggled to learn the history and physical.

One age done; another begun.

Then the greatest challenge. In the sixth age, we played the medical clerk. Charged with new responsibilities, we put ourselves through the paces, sometimes jealous in honor and quick in quarrel, always seeking the bubble: reputation.

One age done; another begun.

And then the calm before the storm. In the seventh age, we played the confident senior. Full of wise saws and modern instances, we chose our future livelihoods. Today, our hearts singing with pride, we accept the doctor's hood.

One age done; another begun.

Let the eighth age begin. □

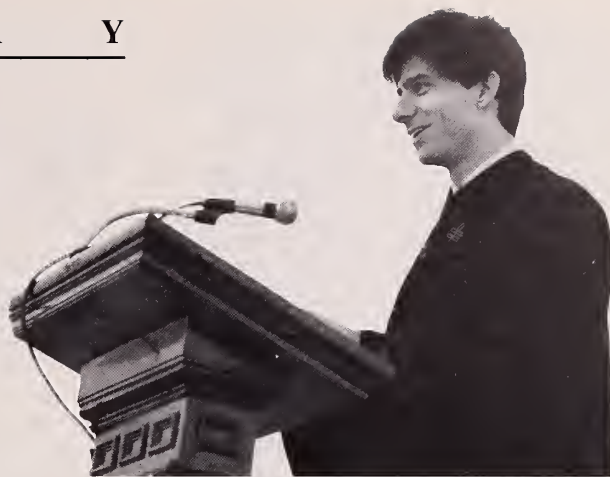


Martin Samuels helps James Wong with his hood

Recent Developments in Medicine

On facing the brave new world, from AIDS to DRGs

by Albert M. Maguire '86



The number of recent advances in medicine has been overwhelming. Those massive textbooks, hundreds of pounds of them, that we have acquired since orientation week are all out of date. Consider a few of the medical developments since we began our education at HMS just four years ago.

Prior to 1982, the year our class entered medical school, the term "acquired immune deficiency syndrome," or AIDS, did not exist in the medical literature. As we began our clinical rotations, the viral agent causing this new disease was isolated by French and American scientists. Last year, an FDA-approved blood test for detection of antibodies to the AIDS virus was marketed; it is now being used to screen blood donations. Today, prospects may exist for a vaccine.

In our second year of medical school, in a major research breakthrough, the gene for Huntington's disease was localized to chromosome 4. Now a newly synthesized DNA probe allows us to diagnose this fatal disease early in its course, thus enabling affected individuals to plan for their families and their futures.

As we sat listening to our lectures in human reproduction, an eight-cell human embryo fertilized in a petri dish was sitting in a storage refrigerator at 320 degrees below zero. After two months in the deep freeze, it was thawed and implanted into its mother's uterus, later resulting in the birth of a normal infant. *In vitro* fertilized embryos have even been successfully transplanted into unrelated recipient women. The astounding progress in the treatment of fertility disorders boggles the minds of ethics committee members and science fiction writers alike.

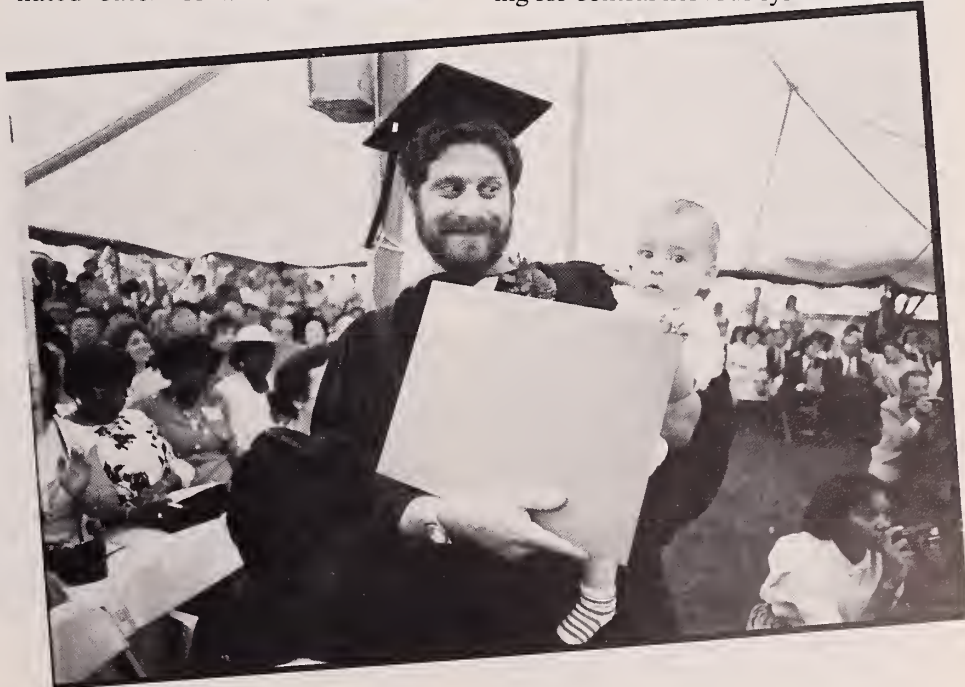
Over the past four years, we've

seen the promise of the biotech industries pay off. We are now able to prescribe an entirely new class of drugs: purified proteins produced by recombinant DNA technology. The year after we started medical school, humulin—the first purified human insulin—was marketed. The following year, tissue plasminogen activator, a highly specific clot-dissolving agent, was synthesized; it is now being used in the treatment of acute myocardial infarctions. When we started our clinical rotations, a recombinant hepatitis vaccine was developed, thus eliminating the risk of exposure to contaminants in the vaccine developed from pooled blood. This past year, growth hormone produced by recombinant techniques replaced pituitary-derived growth hormone, a contaminated batch of which had caused

deadly brain infection in a group of children.

Just a few months ago, HMS's own \$23 million gamble paid off: not Megabucks, but angiogenesis factor. Bert Vallee, Paul C. Cabot Professor of Biochemical Sciences, cloned and sequenced a protein called angiogenin which promotes the growth of new blood vessels. Angiogenesis factor now awaits its future clinical applications.

It used to be that at every lecture we were asked if we had ever heard about that amazing new machine, the CAT scanner. Come on. This is 1986. Have you ever heard of MRI? Magnetic resonance imaging is actually the old nuclear resonance technology with a new, anti-nuclear name. It is now the preferred method of imaging for central nervous system lesions.



Steve Simon and Molly

This powerful device promises to repeat the history of the CAT scanner as it wipes out magnetic bank cards and multimillion-dollar hospital budgets alike.

During our first year of medical school, William DeVries implanted a mechanical heart into a 61-year-old man dying of heart disease. Barney Clark survived 112 days with the Jarvik-7 device. Leonard Bailey transplanted the heart of a baboon into a newborn infant suffering from a fatal heart malformation. Baby Fae survived 20 days with the baboon heart. Are we surprised to find that in 1964 James Hardy performed a cardiac xenograft with a chimpanzee heart? Or that Denton Cooley performed an artificial heart transplantation back in 1969? Compared to these crude attempts of the '60s, our recent successes have been underwhelming. In this field, at least, nature keeps us humble as ever.

There has also been a host of new syndromes with names like cymbal player's shoulder, lawn mower arm, French vanilla frostbite, blizzard of '83 erythrospia, jet-ski rhabdomyolysis, sunflower seed bezoar, and water-ski colon. I myself have suffered from one of these menacing illnesses, and I can only hope that medical science will provide me with some relief in the near future.

Finally, let us not forget the new economy that has evolved in medicine, based on DRGs, or diagnosis related groups. The week the deans first greeted us as incoming students, President Reagan signed into law a prospective payment system for Medicare-related expenses, thus ending the traditional fee-for-service reimbursement for care of Medicare patients. Today Medicare pays by the diagnosis, or DRG, not by the treatment. Hopefully, the day is not far off when the same system is used for car mechanics and government contractors.

Today, not only do we have entirely new diseases, tests, drugs, and treatments, we have new patients—more outspoken, more diverse. We ourselves are different—we don't even wear our stethoscopes the same way anymore.

Now that we've graduated, we must not only adapt to the post-1984 society, but remain flexible enough to adapt to the brave new world of the 21st century. That is our challenge.

I look forward to that challenge, and to seeing the Class of 1986 at our 15th reunion—in the year 2001. □

C L A S S D A Y

The Returns Are In

Poll results on what got the class of 1986 through HMS, from Harold the mailman to Big Sami's sandwiches

by Roger E. Mosesson '86

I polled my classmates over the last couple of months of medical school to find out what they thought they would remember on Class Day. After all, commencement is not only the beginning of something; it is an ending—an occasion for remembering, for focusing on the past. Our families did not come to Class Day to see us commence, they came to see us graduate. Finally.

I therefore leave it to other, wiser people to speak truths about our future. Consider instead the past, the fact that the Class of '86 has finished, ended, concluded, terminated. I think you've got my drift.

So here are some of the results of my poll. Members of this year's graduating class predicted that on Class Day they would think about their classmates—those who joked in labs, and those who commiserated over pizza about biochemical pathways and the difficulty of constituting the underground portion of the hospital totem pole. Classmates who came to the rescue at 2 A.M. when the new patient's chart still needed work but the old patient's blood needed to be drawn. Classmates who shared in running, swimming, hiking, biking, and rock climbing. Those who became mates. Some who began with us but for one reason or another did not finish with us.

Graduates thought they'd remember spouses and significant others—for being guinea pigs while we learned the physical exam, enduring our endless and graphic descriptions of what goes on in hospitals, and, most of all, for sanity and perspective (symbolized by chocolate chip cookies for at least 10 members of the class).

We knew we'd think about the pre-clinical teachers who really worked

to teach us, the special teachers on the wards who gave their time and thought, the nurses who helped in so many ways, and the patients. Some of the patients had broken bones. Some had broken hearts. Many had broken accents. We thank them for teaching us so much.

Also on the class's list of what helped get us through medical school: Carola Eisenberg and coffee and cookies in the Student Affairs office. *Vogue*, *Glamour*, and *Cosmopolitan* magazines. Harold, the mailman at Vanderbilt Hall. A bird in the Quadrangle, a house finch, whose song was powerful medicine for at least one person during the second year. And urgent overhead pages at Brigham & Women's Hospital crying for the baby photographer.

Food, of course, is part of what enabled us to get through HMS. My survey indicates that the eateries we are to remember most are Big Sami's and Chef Chow's. We're hoping to remember someday places like Maison Robert.

I wish I could report that there was a single official junk food of the Class of 1986, but the voting was tied. It seems that Pop Tarts and Hostess Fruit Pies sustained equal numbers of students here through their medical school careers. I am pleased to report that there was a hands-down favorite class candy: M&M's. Peanut M&M's. Even the green ones.

Graduation isn't just the end of our time in medical school. For most of us, it marks the end of our careers as students. Most of us cannot even remember a time when we were not students.

Warning: I'm coming to the corny part.

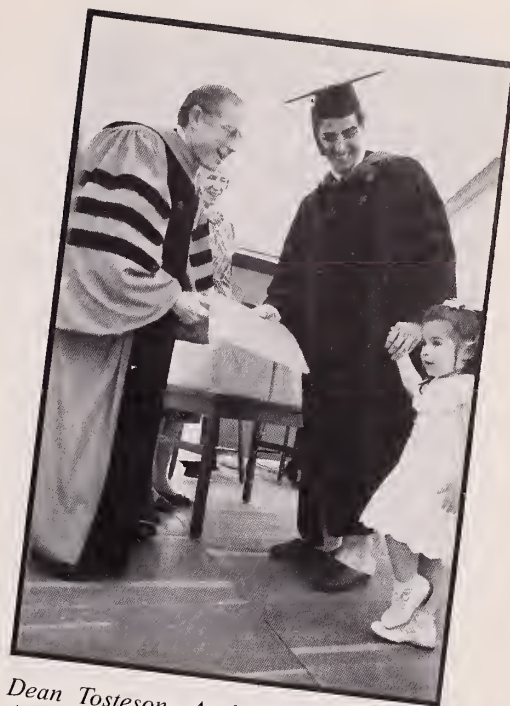
Many graduates are thankful to



Thank you for worrying about us, for working with your hands so that we will be able to work with our heads, for knowing when we are drowning and when we are just waving. For advice like "Don't wash the red laundry bag with your underwear." For passing on the joy of fishing. For teaching us about everything, including some home remedies we now know are hokum (at least we think they're hokum). For the 6,249,588 times you told us not to forget to take a sweater. For understanding when we miss a holiday or a birthday celebration. For reminding us never to sell ourselves short. In sum, we thank you for being our parents whose love is limitless and therefore cannot be expressed in words. Our successes are your successes. We hope you imagine yourselves getting the sheepskins along with us, because we wouldn't have made it without you.

We remember the wonderful teachers we've had over the years—that's 22 years on average. The fourth-grade teacher who insisted on 25 book reports a semester. The high-school teachers who gave us a first taste of science. The college professors who let us sit near and watch the sparks fly.

At least six graduates remember, some kindly and some not so kindly,



Dean Tosteson, Anthony DiGioia, and Angela DiGioia

teachers they have proven wrong—such as that French teacher who told one of us he'd never make it through high school.

When I asked them to think back, classmates thought of their pets—epileptic dogs, cats with leukemia, hamsters with personality, box turtles, and that alligator which should never have been brought back from Florida.

Other influences mentioned in my poll were: Sophocles, Shakespeare, Jane Austen, Sigmund Freud, Groucho Marx, Woody Allen, Lenny Bruce, and the Grateful Dead.

Vince Edwards, Chad Everett, and Alan Alda got lots of mentions—some perhaps remember them as doctors Ben Casey, Joe Gamon, and Hawkeye Pierce. The other two major media personalities that came up were Mickey Mouse and Bugs Bunny. One guy in the class went so far as to wonder if his desire to become a doctor had anything to do with that question Bugs is always asking.

The point of all this is simple. We're the kind of people who constantly look forward to the challenges we're going to face, the problems we're going to solve. Let's hope, though, that we can find the time to stop and think about the past every now and then—because where we're going depends on where we've been. You can't commence until you've graduated. □



Speaking Out—And Listening Too

The doctor as public servant

by Lawrence K. Altman



The Class of 1986 joins the medical profession at an historic moment—historic in medicine's effect on society and society's effect on medicine. The world of medicine differs in many ways from the one you, its newest members, may have dreamed about five years ago when you filled out your applications to medical school.

It is likely that your lives as physicians will differ in some ways from those of the physicians who taught you. Some in medicine and the public speak of the changes behind these differences in derisive terms. Yet largely the shifts are a natural consequence of a dynamic profession and society. And in many ways you young physicians will derive the same satisfactions from caring for patients and solving medical mysteries that have driven physicians for centuries.

The role of the physician has always been to serve the patient. That service—whether in a small office or in a huge medical center—is based on the license to practice medicine that physicians receive from the state. That license carries with it a certain accountability to the patient. Traditionally, the terms of that accountability have been rather loosely defined and implemented. But the time may be coming, as the financing of medicine changes, when those terms will be defined more rigidly and when you as physicians will be held more accountable than doctors have been at any time in the past.

Many of the laments directed at the profession reflect a lack of understanding of the evolution of American medicine. Not long ago, the profession was purely entrepreneurial, though not particularly remunerative. Medical students paid for each lecture. The patient paid the doctor directly out of pocket. The patient-

doctor relationship was rigidly confidential; no one else saw the records. What little research a physician did was accomplished in his or her spare time, and the doctor bore the expense unaided by grants.

Today most medical costs have shifted from the private to the public or semi-public sector. The taxpayer foots the bill for most medical research and much medical education and care. Further, third-party insurers contribute vast sums to the payment of medical bills, and the costs of such coverage are regulated by public bodies.

Even a private institution as venerable as Harvard is dependent on taxpayer monies. Without them, several of its buildings would not have been built. You HMS graduates would have had fewer teachers, and their research projects would have been cut to a fraction. Some of the advice and therapies you offer might never have been developed. We've learned more about medicine in the last two or three decades than in all of history—and most of that new knowledge has resulted from taxpayer-supported research. As expensive as it has been for you graduates, your spouses, and your families to pay your tuition bills, and as deeply in debt as many of you are, medical school would have been more expensive without taxpayer-supported subsidies for your medical education.

Put simply, the bulk of most physicians' income is derived from taxpayer and third-party funds. The medical profession has become a public institution. As doctors, you are public servants in the best sense of the phrase. And in our system of government, if the public pays, the public has a right to accountability.

It may seem strange to think of medicine as a public institution when

there's so much discussion about the growth of for-profit hospitals and private industrial relationships within academia. But do not let such debates obscure the crucial point that these so-called for-profit institutions are publicly regulated, and public officials can exert enormous influence over them, as their revenues are derived from tax funds. The Health Care Finance Administration, for instance, has control over Medicare and Medicaid expenditures whether they are incurred in for-profit or non-profit medical centers. The Food and Drug Administration controls the release and recalls of the drugs and therapeutic devices manufactured by companies.

An unexpected, perhaps unintended, dividend of current debates is that for-profit institutions of science and medicine have challenged non-profit institutions to account to the public in a way they never had to in the past. The situation is healthy for all. Remember, there is as much danger from too great a reliance on a non-profit government system as there is from the other end of the spectrum. Doctors working for governments often face greater restrictions of professional principles than those who are free to choose among competing private groups.

On a recent trip to Africa to investigate AIDS, I found that many physicians were forced by political pressures from African governments to remain silent about a spreading epidemic. Many political leaders apparently are not allowing doctors investigating AIDS in Africa to report all their findings, either in medical journals or to the public. Yet some of that data could be pertinent to the current situation there and elsewhere.

Too little is made about the dangers of political control in arguments

about the relative merits of non-profit and for-profit medical care. In the U.S., one clear effect of the vast taxpayer expenses for medicine is that health care has become subject to the mechanisms of government—the lobbying, regulation, budgetary scrutiny, debates in Congress and state legislatures, and other public arenas that are part of the American political process.

Consumer advocates may force the day when your hospital or clinic must publish data about your rates of success and failure in treating common ailments—and a compelling case can be made for giving the public such a basic accounting. Recently, the federal Health and Human Services Administration released the names of hospitals where death rates were above and below the averages calculated for all hospitals. As there was no attempt to correct the data for type of institution, severity of illness, and other factors critical to evaluating such data, the list was meaningless. It was a sloppy, unsophisticated effort. Nevertheless, it was a warning shot.

Consumer advocate groups are likely to exert pressure for government agencies to use better statistical and epidemiological techniques to analyze the data in more meaningful ways in the future. Such moves have

their origins in studies of hospital efficiency by surgeon Ernest Amory Codman in Boston earlier this century. Codman fought to make surgical techniques, hospital organization, and patient care more efficient. Codman proposed that each hospital establish a follow-up system to trace the outcome of treatment given to each patient. He suggested that a clerk write a routine letter to every patient discharged the previous year, asking the patient to report to the emergency room for a follow-up examination or to reply by letter. Despite problems with medical and hospital politics, Codman left a magnificent legacy.

The need for accountability provides the latest generation of physicians with as great a challenge as there is in medicine—to better evaluate what we do and how well we do it. Such evaluations concern the very fundamentals of this ancient profession, not only in patient results but also in peer review. Working as long and as hard as we do each day, and putting patients through a degree of suffering to make them feel better, isn't it natural to want to make sure that we are doing the best we can? So why not find the formulas that will provide valid data?

You, the members of the Class of 1986, have tools, such as epidemiology and statistics, that were unavailable



Mark McMahon and David Mego

to Ernest Codman as a member of the HMS Class of 1895. These tools can be adapted to provide the accountability that the public demands for the care it receives and its investment in medicine.

Unquestionably, medicine is more scientific today, and has better standards, than 50 or 25 years ago. Nevertheless, the practice of medicine still involves a large measure of art. As physicians, we know that is so, but the public does not, because we have not been as honest as we should be. We sometimes put too much emphasis on how much we know instead of how little we know. Because medicine is now a public institution, involved with the governmental process, it will be your duty as the new generation of practitioners and researchers to speak out—to be leaders. It will be your obligation to fight for what you believe.

Do not repeat old errors. My medical school class was sternly warned not to get involved in politics or public policy. That attitude has contributed to medicine's declining image. The days when doctors kept silent and let others speak for them must end. If not, doctors and their patients will continue to lose ground because that is the way it is in the political process.

Learn to speak out on public poli-



Beverly Spencer and Eric Stein



Scott Phillips

cy issues. If you are handicapped in treating certain diseases by ineffective therapies, and you believe more research funds are needed, get out there and tell the public why, in terms others can understand. Don't bitch to your classmates and medical colleagues; they know. Instead, tell your lay friends, patients, and the public; they do not. Remember, also, that if you have not been a patient, there will be a time when you will.

If the American medical system is under attack and you are being held accountable, go abroad and study foreign medical systems. Find out what the alternatives are. Bring back the good points and explain the myths to your fellow Americans. International health deserves your attention. So much more could be done to help the people of this world live healthier and more productive lives. But even if you are inclined to apply skills in international health, few of you will be able to do so, as funds are inadequate to support this work. To get the funds and programs, professionals must educate the public as to why and how international health programs would benefit Americans as much as the citizens of the rest of the world.

In speaking out, you will have to learn to make the crucial distinction between defending vested interests and defending what is best for your

patients and for society. Many people perceive doctors as acting more in their own self-interest than in the interest of the patient. That is a dangerous perception, as it risks the loss of public confidence and trust—the very foundations of effective medical practice.

Learn to explain medical problems in terms your non-medical friends can understand, not in the jargon that fills the pages of scientific journals. Journals have reached the point where authors sometimes can understand only their own paper but not the others in the same issue. If we can't talk to each other as physicians, how can we be understood by patients?

An amusing incident occurred during the coverage of Barney Clark as the first recipient of a permanent artificial heart. In one of the press conferences after the implantation, a University of Utah physician called attention to the diligence with which surgeons William DeVries and Lyle Joyce were attending Clark. The care was so intense, he said, that one of the Utah surgeons had slept on the floor—our jargon, meaning that he had slept in a room near Clark's. Sure enough, the next day a Salt Lake City newspaper reported the episode precisely. Dr. DeVries, the paper said, was tired. The reason? He had had a poor night's sleep on a hard floor!

Remember that the lay public does not have your access to what goes on in hospitals and doctors' offices. Your burden will be to learn how to explain as if you were on the outside, but with the knowledge only an insider can have. In doing your part to close the gap, you must become effective communicators with the public and with individual patients. Recall how little you knew and how much you have learned since you entered medical school four years ago. Use your imagination in your explanations.

If it took you four years under intense pressure to learn what you know about medicine, and another few years of training to become specialists, is it fair to expect patients to learn about their illness in the few minutes you spend hurriedly telling them? Remember, that communication takes place at a time when a patient is apt to be extremely anxious.

Bear in mind that patients' most common complaint is that their doctors are not attentive enough. Patients say that doctors are too rushed; when

they do take the time, they do not really listen. There is no adequate excuse for this shameful situation. Not listening is a form of arrogance; perhaps that arrogance is what the public dislikes most in their perception of physicians' attitudes.

You expect trust from your patients. You must not only earn it, but also return it in the form of effective service. Of course, patients are not always correct. There never will be enough time in the day to hear everyone's complaints. And the gift for gab is no substitute for knowing medicine. Still, the art of medicine includes doing your best to relate to your patient as a human being—once known as the bedside manner, or the laying-on of hands.

Be attentive to the verbal and nonverbal clues that may lead to a diagnosis. Listen also for the new ideas that can come from a patient's observations that turn out to be medical discoveries. My message then is: speak out, but also listen.

There is a compelling clinical reason for listening. Despite technological innovations, the medical history is still the basis of medical practice. And what is the medical history but an interview and the beginning of a special relationship? Remember, the patient knows more about himself or herself than anyone else. As a physician you have to ask the right question and listen to the answer.

Much of the work of a doctor is being a journalist, an investigative reporter. What distinguishes the best clinicians and medical researchers is that they have learned how to ask the sharpest and most probing questions, listen intently to the answers, and analyze that information. Have someone else test what your patient understood you to say, or do it yourself. And take the time to write down instructions legibly for family members. You need their cooperation, in this day of out-patient care, to help the patient maintain a regimen. My hunch is that when the modern version of Ernest Codman's studies is done, physicians who most effectively communicate with their patients will have the best scores.

Doing well at the job of a physician is as tough a task as there is in life. But if you do it well, there will also be many rewards. □

Lawrence K. Altman is clinical associate professor at New York University and medical reporter for The New York Times.

The Care of the Patient—1986

Applying the lessons of a bygone age

by Ronald Arky

It's hard for me to believe that four years have passed since September 7, 1982, when I first met some of the members of the Class of '86. Among my fond memories of this class's maturation are its anxiety and tension before its first biochemistry exam; its pride in putting together some of what we discussed in pathophysiology to make those first correct diagnoses in Introduction to Clinical Medicine; its gaunt, fallow appearance as it finished that three months in the medical clerkship; and its sophistication, sometimes cockiness, of completing one of those easy clerkships in the fourth year.

Two years ago, as most of the Class of '86 studied intensively for Part I of the National Boards, Marty Samuels appeared on the Class Day platform with his clarinet. Last year as the graduates wound down from the clerkships, my colleague Arnie Weinberg displayed his neckties and discussed the ties that bind us together.

My days as a musician ended in high school, and my wardrobe, let alone my ties, has much to be desired. But there was a person in this place 60 years ago who links me with many of you: Francis Weld Peabody. Peabody was one of the most outstanding clinical scientists this school has known—a humanist, a caring physician, who delighted in spending time with students. His discussions with the members of the Class of 1926 while he was chief of the Harvard Unit at Boston City Hospital are the basis for his classic treatise *The Care of the Patient*. Over the last four years, some of the members of this graduating class and I have wine-dined, and had fun together in the

monthly gathering of the Peabody Society.

There are other connections with the class of 1926—Maxwell Finland, Laurence Ellis, Theodore Badger, Richard Stetson, and Kenneth Mallory. Just names to current graduates, they were my teachers who imparted the humanism and caring of Francis Peabody, a message I hope I convey to my students.

Were I to ask my colleagues in Cambridge who are busy practicing medicine what I ought to tell the members of the Class of '86, they would say, "Tell them that since you first met them in 1982, the medical profession has undergone a revolution. Use the terms 'DRG,' 'PPO,' 'BRO,' and top it off with 'malpractice' and 'balance billing.'"

How would Francis Peabody view the modern world of medicine? With enthusiasm, optimism, and a little of that old Boston Brahmin concern. When he addressed our predecessors 60 years ago, problems were the accepted way of life. He would probably claim that there is still, if not more, need for humanism, understanding, and caring. Even in this world of magnetic resonance imaging, genetic engineering, and transplantations, he would reiterate what he wrote in *The Care of the Patient*: "The treatment of a disease must be *completely* impersonal; the treatment of a patient must be *completely* personal."

There is still a great deal of gratification and satisfaction in clinical medicine—in being a physician. This year, Nancy Field '86 and Sara Feld-

man '86 will experience the pleasure of delivering a healthy baby to a mother with high-risk pregnancy; Paul Cotran '86 and Frank DiGiacomo '86 will share the happiness of parents whose acutely ill child improves; Jeff Schweitzer '86 will receive accolades from the patient whose disc-generated pain is relieved with surgery.

There is inherent in the profession of medicine a sense of satisfaction not equaled in any other profession. Peabody would stress the need for establishing a warm, personal relationship, especially in this era of "quick in—quick out" of the hospital, and all the modern-day obstacles to getting to know patients. Hold a hand—it means so much to the recently intubated patient, anxious and tense. Smile as you watch someone recover from anesthesia in the recovery room—even if you have been up all night. Say "thank you" to the patient who volunteered for a clinical study. Commend your laboratory technician in the clinical or research lab for his or her tenacity and fortitude. These little gestures are vital to the art of medicine.

I say to the Class of '86, your diploma implies that you are now a full-time teacher—a teacher not only of yourself, but of your patients and their families. A major chore of a faculty member such as myself should be to "teach you to be a teacher"—a job that is still perhaps inadequately done at this medical school. As Peabody recommended, "make time to have little talks with your patients." Relate in the patient's language what is known about the disease process you are treating, why you are approaching the problem in the manner



you have chosen, and what the patient can expect.

In this "fast-food" world, we are all anxious to complete our busy schedules and move to the next challenge. But that short period of time spent informing the patient is vital to the personal relationship. Specialty plays no bias—the pediatricians with parents, the ENT surgeon or urologist with elderly patients, the radiologist with the anxious patient waiting for a CAT scan, all must make time to educate patients.

You graduates have been exposed in the last four years to some of the greatest advances in technology and human biology that medical science has ever known. With each advance arises a series of problems. When should life be prolonged? How much therapy is justified in this elderly patient? When should hyperalimentation be discontinued in that congenitally deformed infant? One can go on and on with the ethical issues you will face daily. These are far in excess in both magnitude and depth of those encountered by Peabody in 1913 when he was appointed the first chief resident at Peter Bent Brigham Hospital.

The approach to these difficult, often nerve-racking, dilemmas call forth the modern-day art of medicine. As Peabody wrote, "The art of medicine and the science of medicine are not antagonistic but supplementary to each other." So often, the establishment of a close, intimate relationship with a patient or family eases the burdens imposed by difficult ethical dilemmas. The realization that each of us—ourselves, our families—may face similar critical issues often helps assuage these dilemmas. Difficult ethical decisions are made easier by the ties among physician, patient, and family. Strive to create such bonds.

Every few minutes on the radio or television, we are bombarded with a plea to join this or that health plan ("We give you health care for a cheaper rate"). That cry becomes the modern-day refrain analogous to "I can get it for you wholesale." Peabody would shudder at the constant reference to the terms "bottom line" and "product lines." Yet sales pitches are facts of our modern-day, commercial, competitive life. Our primary responsibility as physicians is to be advocates of our patients. That role does not in any way diminish our understanding

of societal and community needs. Having a grasp of the business side of medicine is important. Fluency with managerial terms is part of our education—while our responsibilities lie with the individual patient. We must be sure that each patient receives the optimal care necessary for his or her well-being, while we respect the concept of efficiency and understand the financial background of treatment.

Humanism in a physician requires care and understanding not only of himself or herself, but of family and friends. Long hours of physician work often deprive spouses or children of the care and attention they want. A successful physician must balance a rich professional life with a rich outside life. You, the Class of '86, are as a group highly talented in both professional and cultural skills. Continue to give attention to those cultural skills; they nurture you, and make you better physicians.

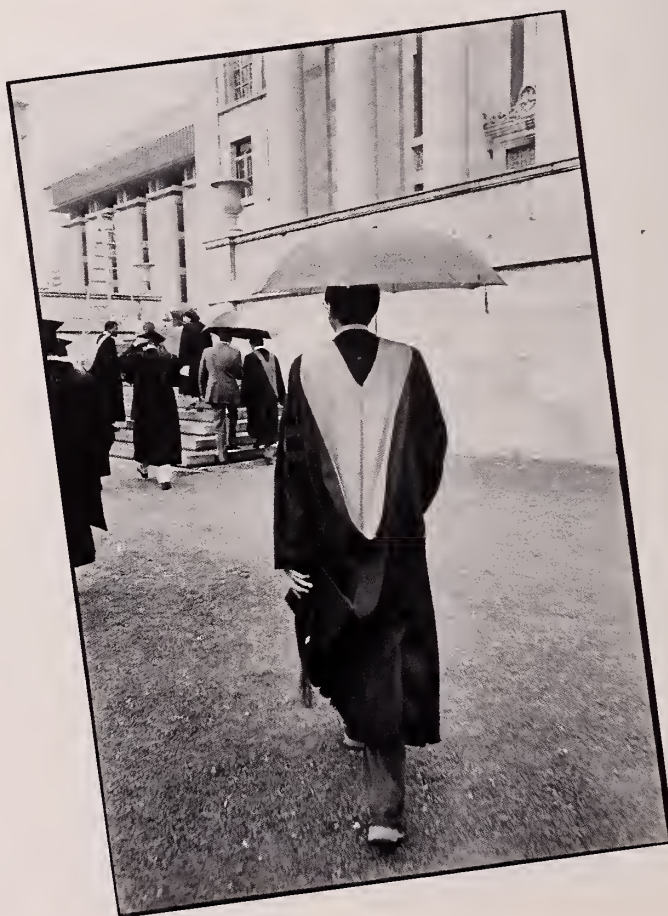
Francis Peabody traveled first to Europe and then to China to establish the early bonds between Harvard and Peking University. I urge you to do the same, to see other cultures in the world, and to realize that the enrichment from such experiences in Africa, Central America, China, and elsewhere, will make you more effective

physicians. I do so with concern, knowing that you are heavily in debt. That financial burden felt by so many of you is of deep concern to this faculty and its alumni.

In closing, I thank the Class of '86 for giving me the honor of delivering a Class Day address—but I must do so in a secretive, *sotto voce* manner. For as a group this class has provided me a great escape from the turmoil and chaos to which my colleagues would refer. I have gained much satisfaction in being informed of your research activities, listening to your presentations and discussions of cases, and hearing about your problems and concerns.

Medicine is still an unsurpassed opportunity. The gratification, personal pleasures, and pride in correct diagnosis, treatment, and happy outcome, have no parallels in the world. There is still a generous place for humanism and for the care of the individual patient. Reap the enjoyment of a close relationship with patients, and in doing so, learn to have fun. □

Ronald Arky is Charles S. Davidson Professor and chief of medicine at Mt. Auburn Hospital.



REUNION REPORTS



55th Reunion

Twenty members of the Class of 1931, 18 accompanied by their wives, came for our 55th reunion activities. The loyalty of the out-of-staters was outstanding; they equaled in number the Massachusetts residents who attend-

ed. Our class's attendance at the scientific symposia was small—not surprising, since we are mostly retired and no longer need Brownie points.

Thursday evening we dined, 35 strong, at the Union Club. We were welcomed by Langham Gleason '89, representing the Alumni Office. The Reunion Committee is most grateful to the Alumni Office for taking full responsibility for all arrangements—largely, we suspect, because we were

not trusted to do it ourselves, due to our advanced age.

Because John Hubbard, our president, was unable to come for health reasons, our committee felt an acting president should be elected. Henry Clifford nominated George Dunlop *in absentia*. No other nominations being made, George was elected by acclamation. The assembled company deeply regretted the absence of John and Dee, and voted that an ap-



appropriate message be sent to them.

No other business seemed indicated, so none was done.

After a delicious dinner, various classmates regaled us with reminiscences of our undergraduate days. The party broke up early and we departed into the deluge of rain which had persisted since early afternoon.

Most of us attended the Alumni Day exercises on Friday, which were forced indoors by the inclement weather. The luncheon line was long, but kept moving steadily through the tunnel and up the stairs of Building A. We reached the first landing close to exhaustion, but were revived by our thoughtful dean for students and alumni, Dan Federman, who passed us cups of beer. Thank you, Dan!

—George Sturgis

50th Reunion

Dedicated alumni in profusion assembled in amphitheaters C and E on Thursday, June 5, to hear the speakers in the scientific symposia. The

Class of '36 was well represented, and 33 of them, the majority with wives, later that evening gathered at Anthony's Pier 4 restaurant to enjoy cocktails, dinner, and the wise and comforting commentary of their guest for the occasion: Arthur Hertig, Shattuck Professor of Pathological Anatomy emeritus. We heard that an anonymous donor, a friend and patient of Tillman McDaniel, had given a six-figure sum to HMS to establish a student loan fund in McDaniel's honor.

Friday, June 6, began with the meeting of the Alumni Association, memorable for the essay of James Oliver '87 and the gleeful conduct of the annual business meeting by retiring president Clem Hiebert. Luncheon and the traditional reunion class photographs were severely complicated by the torrential rains that made use of the tents impossible.

In spite of the weather, our mates made the trip to Osterville as scheduled and gathered once again at Evelyn and Lang Hooper's for the opening festivity of a truly memorable weekend renewing the strong ties of class feeling and reminiscence.

As it had for our 45th reunion, the Wianno Club offered ideal facilities for the meeting of a group the size of ours. Dinner on Friday was informal and delicious. We enjoyed Saturday cocktails at the lovely stu-

dio where Ann and Nate Talbot express their impressive talents.

Dinner that evening took somewhat the format of a reunion banquet, with toasts of recognition for those who had contributed to the success of the reunion, a moment of silence for the 44 men of the class who have died, and the presentation by McDaniel of a complete file of his semiannual appeal letters to the class agent who had composed them.

As a fitting finale, Paul Zamecnik related the saga of his experience as a fellow in Professor Lindstrom-Lang's laboratory in Denmark at the time of the Hitlerian takeover.

The evening closed with Hooper on the violin and Pearson at the piano leading the group in songs of yesteryear.

In all, 40 members of the class attended some part of the reunion, and many expressed the opinion that the inclement weather, instead of spoiling things, significantly contributed to the feeling of community by preventing the scattering of people in a variety of activities indoors and out. There was even a groundswell of opinion that we should explore the possibility of meeting annually from now on, at least for a dinner after the scientific symposia.

—Howard Ulfelder

45th Reunion

The 39 classmates, 34 wives, and assorted offspring and friends who attended all or part of the Class of 1941's 45th reunion activities declared that this reunion was the best ever, despite the weather.

We gathered on Thursday evening at the Parris Room at Quincy Market for cocktails and dinner. Joe Foley gave the most amusing after-dinner talk: a scholarly discussion of the mispronunciation of the word "dissect" and other words beginning with "dis." Bert Kanwit entertained us with his brief experience as a psychiatrist in the military.

Following the Alumni Day exercises, members of the class drove to the Chatham Bars Inn for the weekend. There was a great deal of camaraderie as we became reacquainted

with one another and caught up on old times. Mealtimes and cocktail parties provided the most enjoyment. A few people played golf despite the rain; many shopped and toured Provincetown; some stayed up rather late. All in all it was a tremendous reunion enthusiastically supported by all present. We were joined by the Class of 1966, who added their pleasant companionship to our reunion activities.

Class members in attendance included: J. Allen, B. Bennison, M. Berg, J. Byrne, F. Carter, M. Carter, G. Clowes, J. Craig, P. Culver, W. Daniel, E. Edgar, S. Feder, A. Finck, J. Foley, I. Frantz, R. Hallborg, C. Hamlin, C. Hinman, B. Kanwit, P. Knapp, E. Landsteiner, A. Linenthal, R. Miller, F. Nulsen, A. Pope, W. Potter, C. Prout, J. Richter, T. Risley, T. Sappington, D. Scott, W. Seaman, B. Selverstone, J. Sholl, C. Sommers, R. Thirlby, A. Tucker, F. Tucker, and T. Young.

—Perry Culver



40th Reunion

Our 40th reunion found the amenities all just a trifle nicer than five years ago, and the classmates just as glad to get together.

There was a large and enthusiastic gathering of alumni and their spouses at dinner at the Tavern Club on Thursday evening. The weekend at Wequasset Inn began with a clam-bake which went every bit as well indoors as it might have if the sun had been shining. Clouds and fog did not detract from the views, and the rain did not detract from meetings and conversation. The setting of the inn could not have been nicer for getting together.

The privilege and pleasure of being able to talk at length with those whom we have known over so many years cannot be overestimated. I strongly urge every classmate to plan on attending our 45th reunion and to come to reunions in the interval if possible. The time allotted to reunions is short, and we have many years of adventure and amusement to share.

As editor of the 40th Reunion Report, I regret the transposition of my percentage figures for the number of us who are retired versus those who



are active. On closer scrutiny of the data, I conclude that of the 69 classmates whose biographies were available, 15 (22 percent) are retired, 11 (16 percent) are partially retired or soon to be retired, and 43 (62 percent) still have their noses to the grindstone. My impression from our weekend together is that whether we are retired or not, most of us are enjoying an increasingly varied set of activities outside our regular work.

—George S. Richardson

35th Reunion

On June 5, 1986, the Class of 1951 assembled to commemorate its association of 35 years. Classmates came from Puerto Rico (Woodburys); the sea (Weisses on their boat); sickbeds (Bob Reid, supported by Betsy); the West (Skinners, Faheys, Kleavelands, Giles Toll); mid-country (Danforths,



Tetiricks, Fernalds, Jane Sears, Tom Haymond); the South (Curtins, Hayneses, Richardsons, Jean Ross); and closer by (Richters, Snows, Hieberts, Fischbeins, Burkes, Yaffees, Robeys, Galdstons, Fosters, Art Cain, Aaron Weiner, Helen Hess). Oh, yes, there was an old seafaring-type chap who insisted his name was Zeke Lamdin—but no one recognized him.

We dined sumptuously at the old Harvard Club, accompanied by a charming babysitter, Sidney Rubenstein '89, who chose us over other classes because on paper we seemed to possess verve and dash. This young man represents a bright future for HMS as well as good advertising for Jerry Foster, director of admissions. We thank him for assisting Jack Burke, Jerry, and the reunion committee.

The dinner was filled with good cheer, reminiscences, and feelings of loss for those who were missing. Pat Geschwind and Selma Damon joined us; we were glad to see them.

After dinner came the speeches. Jerry Foster spoke of the changing demography of the HMS student body, now 40 percent women. Class president Elbert Tuttle addressed us in his mellifluous voice, and Alumni Council president Clem Hiebert entertained us with a series of bedroom tales. When asked to speak, I was speechless (some say for the first time). I guess this is the year Yaffee gets Alzheimer's.

Alumni Day broke to a pouring

rain. Mercifully, someone had the compassion to move the exercises indoors. Once more I found myself in the lecture hall of my youth. Once more I was treated to the soporific tones of my teachers. I thought I saw a phantom: the spirit of Jack Bradshaw streaking toward the door.

As I looked around, I was struck by the changing appearance of our classmates. People I had not recognized on meeting at dinner the night before were again unrecognizable in profile. Slowly I readjusted and saw Al Skinner and Tor Richter again. I was glad we were still relatively healthy.

Clem Hiebert's address was a humane and touching talk appropriate for the company of giants of medicine like Karl Menninger '17, now in his 90s. We all applauded when Clem mentioned that a beneficent donor had given HMS a large contribution in honor of Tillman McDaniel '36, who in our day was physician to the students.

After the exercises, we left the lecture hall and fought our way to the food lines (some of us via the john, which had even longer lines). The long wait served one important function: as Dan Federman raced up and down providing nurturing fluids for his parched constituents, we were reunited with many more people than we would ever have had time to meet otherwise.

Why did some of us come back and others not? Some are looking for

a lost youth, promises unfulfilled, lost loves, history to be relived, or just plain sentiment.

Jerry Foster observed that we seem to be moving into two groups. The first is winding down to seek the joys and rewards of a career well spent; the second is revving up for new challenges, zests, and vistas.

That afternoon the class (*sans moi*) journeyed to Cape Cod to continue their reminiscences over the weekend. There the Goodriches, Plums, Bikoffs, Arnsteins, and Watsons joined the group. Yale don Al Novick spoke movingly of his new life's work on AIDS, one of the most complex and challenging medical and ethical problems of our day.

To quote President Tuttle, "See y'all at the 40th!"

—Howard S. Yaffee

30th Reunion

The Class of '56 met for its 30th reunion with the knowledge that "things would be different," as Joel Alpert put it at the 25th.

More than 70 gathered at Barrett's on Boston Harbor in the refreshingly renovated Charlestown Square area in sight of the USS *Constitution*. Recognition came at a glance, accompanied by fond handshakes and hearty greetings. Our children are grown now, and we talked again about ourselves.

There was a large West Coast contingent, including Altrocchi, Bush, Franklin, Halperin, MacLeod, and Stiles; a Midwest delegation of Cookson, Fallon, Grover, Lafferty, Perlmuter, Sabath, and Shafron; Texans Korndorffer, Stell, and Tashima; and a strong East Coast and local group.

Due to the next day's rainy weather, Alumni Day was held in Amphitheater C, which added some closeness and a dim reminder of Eugene Landis and Baird Hastings. The panel from the Class of '61 interested us all, and the reading of the student prize essay, "Social Admit," reassured us that medical students' life on the wards and their perceptions of it have changed little. Not so comforting was economist David Birch's corporate vision of medicine's future.

Clem Hiebert's humor (better now than when he was our anatomy instructor), Dean Tosteson's educational innovations, Joseph Murray's recovery from a CVA, and the presence of Karl Menninger '17 added to a memorable Alumni Day.

After lunch in Building A, classmates and spouses headed for Newport to continue the activities and discussions that have welded our friendship for 30 years. We are grateful to those who made arrangements, especially Dick O'Hara, Larry Baker, Stefan Schatzki, and Joel Alpert.

See you at the 35th!

—Lon E. Curtis

25th Reunion

It was altogether a perfect 25th reunion. The extraordinary weather only intensified the experience.

A cold New England rain—a bloated reincarnation of the storm that drove us into the Boston Latin School auditorium for our Class Day in 1961—took control of Alumni Week, sending the organizers scurrying for meeting rooms and dry places to serve food. From Thursday to Sunday, all distractions were under water, and we were pinned in small places, waiting in doorways for a break in the rain or doubling and tripling up for rides to the next event. But the Class of '61 rose to the occasion, and light-hearted conversation erupted everywhere. Twenty-five years of personal history could be swept aside in a sentence and old discussions resumed among friends as if there had been only a momentary interruption.

Mike Lane, Joe Fischer, and Jack Wilber gave us a fine symposium on Thursday afternoon. Ron Weintraub and Bob Leinbach supplied introductions and a few comments of their own.

Dinner that night at the downtown Harvard Club was a grand opening act to our festivities. Emcee Tenley Albright “coaxed” a few words from faculty and student guests and found herself presiding over a little theater with contributions from Royce Moser, Peter Liebert, and Boylston Society historians Pierce Gardner, Newt Hyslop, and Dave Lewis. To top it



off, Helen Randolph provided some lovely reminiscences about how we look as friends and doctors.

Ren Zimmerman chaired Friday's Alumni Day ceremony, which included addresses from Tenley Albright and Herbert Benson.

By Saturday, even our retreat site in York Beach, Maine, was gripped by drizzle and fog. There we had good food, a cliff walk in the rain, more food, some shopping and talking, more food, and—thanks to an im-

promptu production committee composed of Mike Connell and Buck Frederick—a complete airing of our famous creation *Edipus Colonus*, including encore performances by members of the original cast.

Many thanks to the hardest-working members of the reunion committee: Muriel Sugarman, Tenley Albright, Bill Otto, and Ren Zimmerman.

—Jim Warram

20th Reunion

A total of 87 classmates and families attended some of the four-day festivities for our 20th reunion, with 76 coming to our house Thursday night for the kickoff of the weekend's social get-together. Thanks to Jay Kaufman's skillful management of our treasury, we were able to enjoy quite reasonably the joys and ambience of a Chat-ham Bars Inn weekend.

Daytime activities included beach-walking (the sun was limited), tennis, golf, a keen beach volleyball game among about 25 of us, led by Scott Nelson, and shopping. (Jill and David Scharff, both practicing psychiatrists, bought two antique couches.)

Most of all, the pleasant surroundings and lovely dining gave us all the opportunity to relax and talk with one another. The Class of 1941 joined us for cocktails and a clambake-lobster feast, at which Perry Culver, who can never resist the chance to speak, took appropriate and acknowledged pride in having been the CEO who selected us for admission.

Special kudos to Phil Stubblefield, Jim Gordon, and Tom Gettelfinger for leading a discussion Saturday evening on our mid-life and mid-career observations and concerns.

The whole weekend was relaxing, fun, stimulating, and enlightening. Our classmates, spouses, and close friends all have amazing breadth (though none was overweight), as well as wonderful humor.

—Bill Shipley

15th Reunion

The Class of 1971 enjoyed a successful reunion despite poor weather. When lunch in the Quadrangle was washed out, we retreated to the first floor of Building A, where Dan Federman passed out the beer.

The class photograph inside Building A belies the numbers attending the reunion. Approximately 35 adults gathered at the Tavern Club for a nice dinner, good wine, and camara-



derie. Some of us were able to relate the current activities of others who were not able to attend. Only the premature departure of the manager, who had the only key to the liquor room, somewhat dampened our spirits.

Reunion activities culminated with a clambake at the Donaldsons', the

site of many delightful class gatherings in the past. Although the ground was wet, the heavy rains abated long enough for 50 adults and children to enjoy the outdoors and unique New England fare.

We all appreciate Mrs. Donaldson's warm hospitality and the efforts of



Mark Goldman, who graciously served as editor of the reunion book.

—Frank G. Berson

10th Reunion

Five years ago in this space, Ted Kohler quoted the refrain of our fifth reunion: "My God, We Haven't Changed At All!" Ditto. Ten years have gone by, and still we have not changed much. Jerry Paccione still drives the same van, although Marshall Jacobs did not wear taped penny loafers to the reunion and Eliot Nierman was beardless.

About 75 adults (classmates and spouses or significant others) attended one or more event during the three-day reunion. Some 65 people gathered at my house on Thursday night for a get-together, and about half that number braved the pouring rain and Boston's Friday night traffic to gather at Quincy Market for dinner the following evening. Marvin Bittner received a standing ovation for reciting an original poem on roundsmanship, using

rutabaga as a prop. (You had to be there.)

The heavens closed their floodgates for about six hours to allow for a reasonably dry, although cool, clam-bake at Hugh Auchincloss and Laurie Glimcher's house in Manchester-by-the-Sea. In addition to the 65 or so adults, there were 35 to 40 children, ranging from babies to teenagers. The number of children per married classmate is 2.2, by the way, a number not significantly different from that in the population at large (p-value on request). Greg Bazylewicz graciously and spontaneously treated a smaller group for dinner at his house in Manchester.

Most of us are spending the majority of our time taking care of patients, although some are doing research full time. Everybody seemed fairly content and certainly much better rested, with sleep deprivation being more often due to children rather than patients.

Many new stories were exchanged and some old ones remembered. It was good to see everybody. Hopefully there will be more of us in five years!

There are more class reports available for those who did not receive one. Let me know if you want one.

—Tom Aretz

5th Reunion

Our class joined the Alumni Association in June 1981 with a roll of thunder and a deluge of rain. It seems only fitting that Alumni Day of our fifth reunion year should also be moistened from above. The continued downpour apparently drove the festivities indoors and limited our class's attendance to near zero. (I have this by report, since I was untimely tied up in the lab by an unruly possum.)

Although drizzle continued on into the evening, Pat and Sesh Cole, who were in the middle of packing to move to St. Louis, dispelled any lingering hint of gloom with their hospitality and good cheer. Saturday broke with equal bleakness, but thanks to the quick wits and rapid dialing finger of Sandy Stradtman, the only available tent in Boston miraculously appeared between the Torchiana and Hergrueter estates in Melrose, and the rain was held at bay. Over hot dogs, steamed clams, lobster, and corn, many tales were told and many small offspring kept track of. It was a time for renewing friendships and catching up. This all may sound nearly heroic in scale; it was.

From all of this several observations arise: we have gotten older and (some of us thought) more mature, and we have begotten a quantity of beautiful and well-behaved children. We missed many of our friends who were unable to come.

This is a time of great transitions, especially for those of us in medicine. Fellowships are ending and we are looking forward to starting practices (on Park Avenue?), becoming junior faculty members, or, in the cases of those already well established, branching out into new fields of interest. The surgeons among us, for the most part, are still in training, but even here there are rumors of impending moves.

Overall there was an air of general optimism, which we hope will remain in another five years. Our thanks are due to the Torchianas, Hergrueters, and Coles for their hospitality and to Sandy Stradtman for his organizational endeavors. May our 10th be as enjoyable.

—Jay Culver



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